THE / LE ROYAL

1145 avenue Carling Avenue
Ottawa ON K1Z 7K4
theroyal.ca / leroyal.ca

Tel. / Tél. 613.722.6521
Toll free / Ligne sans frais 1.800.987.6424

rTMS Clinical Research Studies
Physician Referral form

Location: The Royal's Institute of Mental Health Research (IMHR)
Sara Tremblay, PhD, Scientist & IMHR Psychiatrists

The Neuromodulation Unit is looking for participants with treatment-resistant major depressive disorder to take part in our repetitive transcranial magnetic stimulation (rTMS) clinical research studies.

Please note that all referrals are not automatically accepted. Patients will be contacted by telephone and pre-screened for suitability for a consultation with an IMHR rTMS clinic psychiatrist, which will be followed by a screening visit with the study research coordinator to establish if they are eligible to participate in the rTMS study. The IMHR psychiatrist in the rTMS clinic will provide a consultation report with a treatment plan to the referring physician and to the patient's primary care provider.

If your patient suffers from a major depressive episode and you would like them to be assessed for any of our current studies, **please complete the attached referral form and fax to 613-798-2973**. If you have any further questions, please find contact information on the attached form.

Sincerely,

Sara Tremblay, PhD, Study Investigator
Neuromodulation Unit

For more information about the study, please contact Stacey Shim at stacey.shim@theroyal.ca 613-722-6521 ext. 6356

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Below is a checklist for the consultant to complete:

Inclusion criteria (*<u>all</u> criteria must be met*)	✓
Male/female, must be ≥ 18 years of age	☐
Primary or predominant diagnosis of major depressive disorder as a single or recurring episode, without psychotic features	☐
Depressive symptoms have not improved after ≥ 1 but ≤ 7 adequate dose of antidepressant trial in the current depressive episode	☐

Exclusion criteria (*if one exclusion is checked, the subject is not eligible*)	✓
Current or past (< 3 months) substance (excluding caffeine or nicotine) or alcohol abuse/dependence, as defined in DSM-5 criteria. **Exception: prescribed cannabis*	☐
Acute suicidality or threat to life from self-neglect	☐
Are pregnant or breastfeeding, or thinking of becoming pregnant during course of treatment	☐
Have a specific contraindication for TMS (e.g., personal history of epilepsy or seizure, metallic head implant, pacemaker)	☐
*Organic causes to the depressive symptoms (e.g. thyroid dysfunctions) have **not** been ruled out by the referring physician	☐

<u>Note:</u> This is not a complete list of inclusion/exclusion criteria. All criteria will be assessed prior to participation in the study. If interested, participants have to agree that their primary physician is informed.

Baseline investigations for ruling out possible organic causes to be sent to our clinic prior to the patient being scheduled, include:

Complete blood count (CBC) and differential	Thyroid stimulating hormone (TSH)	Vitamin D – OHIP coverage for specific criteria*
Electrolytes, extended electrolytes: Na, K, Calcium, Mg, Phosphate	Fasting Blood Sugar Level (GBSL) and HbA1c	Vitamin B12
Blood Urea Nitrogen and Creatinine (BUN & Cr)	Fasting lipids (cholesterol, triglycerides)	Folic acid
Liver function tests (LFTs)	Iron (ferritin)	Urinalysis

* https://www.health.gov.on.ca/en/public/programs/ohip/changes/docs/MOH_Vitamin_D_FAQ.pdf

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PHYSICIAN REFERRAL FOR rTMS TREATMENT

Date of Referral: _____

Patient's Name: _____
First Middle Last

E-mail: _____ Health Card: _____

Patient Address: _____
Street Number & Name City Province Postal Code

Telephone Number: Home: (____) _____ Mobile: (____) _____

Does the patient consent to voicemails at these numbers? Yes ☐ No ☐

Biological Sex: Female ☐ Male ☐ Other ☐ D.O.B.: _____
DD-MMM-YYYY

Is the patient's primary care provider (PCP) aware of this referral? Yes ☐ No ☐

Is the PCP willing to remain involved in the patient's care during the rTMS study participation and upon discharge from the rTMS clinic (*if applicable)*? Yes ☐ No ☐

CLINICAL INFORMATION

Has the patient received brain stimulation? ☐ rTMS ☐ MST ☐ ECT ☐ None

If any have been checked off, please indicate details (i.e. treatment type, # of treatments received, any response achieved, when/where it was done):

What is the patient's primary/predominant mood diagnosis?

☐ Major Depressive Disorder ☐ Bipolar Disorder ☐ Other

Any comorbid diagnoses (i.e. mood/personality/substance use disorders):

☐ Anxiety
☐ ADHD
☐ PTSD
☐ OCD
☐ Psychotic Disorder
☐ Substance Use Disorder
☐ Personality Disorder
☐ Other:_____

MEDICAL HISTORY

Does the patient have past/current medical conditions/illnesses/disabilities: Yes ☐ No ☐

If yes, please indicate details (i.e. diagnosis, start date, has it been resolved – if yes, when? Any treatment or surgery received?):

MEDICATIONS/PSYCHOTHERAPY

(both psychiatric & non-psychiatric)

Current

Medication Name	Dose	Frequency	Response & Adverse Effects

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Past *(within current depressive episode)*

Medication Name	Dose	Frequency	Response & Adverse Effects

Has the patient done any psychotherapy in the current depressive episode?

☐ CBT ☐ IPT ☐ Problem Solving Therapy ☐ Other: _____

If any have been checked off, please indicate details (dates, duration and any benefits)

RISKS & SAFETY CONCERNS

Risk	Yes	No	If yes, when (DD-MM-YYYY)	Details
Suicide Attempt/Ideation	☐	☐		
Deliberate Self-harm	☐	☐		
Violent Behaviour/Safety Concerns	☐	☐		
Legal Involvement	☐	☐		
Fire Setting	☐	☐		
******If any of the risks are selected "Yes", you are <u>required</u> to provide additional details******				

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Other Relevant Information:

REFERRING PHYSICIAN INFORMATION

Name: _____
First Middle Last

Business Number: (____) _____ Physician #: _____
For OHIP/RAMQ billing

Fax Number: (____) _____

I confirm that I am the patient's MRP and will be involved in the patient's care, while providing ongoing psychiatric care leading up to, during and after the patient receives treatment at the ROMHC. I will review notes/recommendations sent by the ROMHC for this patient. I understand that the ROMHC is not able to provide ongoing psychiatric care.

_____ _____
Signature of Referring Physician Date of Referral (DD/MMM/YYYY)

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PATIENT CONSENT FOR E-MAIL COMMUNICATIONS

Dear patient:

By consenting, you will be allowing your care provider and members of the rTMS research team at The Royal Ottawa Mental Health Centre (ROMHC) to communicate with you via e-mail. As with any online platform, it is important that you are aware of the following risks:

- Any inbound/outbound e-mail messages have the potential to be hacked and seen by others using the Internet. E-mail security can not be guaranteed as it may be easily forged, accidentally forwarded and may exist indefinitely. Thus, it is recommended that you do not use your e-mail to discuss information that you deem to be sensitive. If you do consent to e-mail, please let your care provider know if there is any type of information that you would prefer not to be discussed via e-mail (for example: test results, medications etc.).
- Do not use e-mail for any urgent communications, like in the event of an emergency, as it may not be received/read on time.

Please note:

- Your care provider may make decisions about your care based on information you provided via e-mail.
- If an e-mail has relevant information that is important to your clinical care, it may be copied/summarized into your medical record – similar to any phone communications.
- E-mails containing information relevant to your care, may be forwarded or read by other ROMHC staff members on an as needed basis. Your care provider will inform you if another person will read/respond to your e-mail on their behalf.

By providing your consent, we may use e-mail to communicate with you or your delegated person(s) outside the hospital.

You have the right to withdraw your consent to e-mail communications at any time, just let your care provider know as soon as possible.

By signing below, you consent to e-mail communications and its associated risks.

I _____, hereby consent to the ROMHC group to:
Print Name

☐ Communicate with me by e-mail at: _____
E-mail Address

☐ Communicate with _____, Relationship: _____
Delegated Person's Name

at: _____
E-mail Address

☐ Communicate with the following outside care providers by e-mail: _____

_____ _____
Patient Signature Signature Date (DD/MMM/YYYY)