THE ROYAL / LE
1145, avenue Carling Avenue
Ottawa ON K1Z 7K4
Tel. / Tél. 613-722-6521
Toll free / Ligne sans frais 1-800-987-6424
theroyal.ca / leroyal.ca

rTMS Referral Form for Neuromodulation Clinic

Location: Royal Ottawa Mental Health Centre (ROMHC), University of Ottawa Institute of Mental Health Research (IMHR), 6th floor, Neuromodulation Clinic, Ottawa ON

Fax: 613-798-2973, **Email: RTMS@theroyal.ca**

Patients will be scheduled for a consultation with an rTMS clinic psychiatrist, to assess their suitability and safety for rTMS. Please note that not all referrals will automatically be accepted. The 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 (PCP).

For Referring Practitioners:
• **A Psychiatrist or Family/Nurse Practitioner (GP/NP) is required** to fill out this referral.
• **Referral source must provide continued and ongoing care** during and following the patient's involvement with the Neuromodulation Clinic.
• This referral form is solely for the Neuromodulation Clinic at the ROMHC.
• Please ensure patient provides consent to this referral.

For Patients:
• Intake team will make three contact attempts and will leave a voicemail. If patient cannot be reached, the referring provider will be notified.
• Appointments must be cancelled with at least 24 hours' notice. Patients who do not attend their scheduled appointment without notice will be given one opportunity to reschedule.
• Given that the Neuromodulation Clinic is part of the IMHR, patient may be invited to participate in research activities.
• As the ROMHC is a teaching hospital, patient can expect to have residents or other learners involved in their care.

Referral will be accepted if the following criteria are met:
• Are ≥ 18 years of age
• Experiencing unipolar treatment-resistant depression **without psychotic features**
• Depressive symptoms have **not improved after ≥ 1 adequately dosed evidence-based medication trial or psychotherapy** in the current episode
• No current seizure disorder
• Do not have a specific contraindication for TMS (e.g., ferromagnetic/metal hardware implanted in head and/or neck, implanted cardiac defibrillators and pacemakers etc.)

Note: This is not a complete list of inclusion/exclusion criteria. All criteria will be assessed prior to enrollment in the clinic.

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PATIENT INFORMATION		
Referral Date:		
Patient Name (last, first):		
Health Card # + version code:		
Date of Birth (DD-MM-YY):		
Biological Sex:	Female ☐	Male ☐
Gender:		
Address:		
Telephone #:		
Alternate Contact #:		
Consent to Voicemails?	Yes ☐	No ☐
E-mail Address:		
PCP aware of referral?	Yes ☐	No ☐

CLINICAL INFORMATION		
REASON FOR REFERRAL (***<u>**Please attach most recent consultation and/or discharge note**</u>***):		
Previous Interventional Psychiatry treatments? (e.g. neuromodulation)	☐ rTMS ☐ Ketamine ☐ ECT ☐ Other:_____	
Please indicate details (i.e. treatment type, # of treatments received, any response achieved, when/where it was done):		
Primary/Predominant Mood Diagnosis:	☐ Major Depressive Disorder ☐ Bipolar Disorder ☐ Other: _____	
Comorbid Diagnoses (*if applicable*):	☐ Anxiety ☐ ADHD ☐ OCD ☐ Other: _____	☐ Psychotic Disorder ☐ PTSD ☐ Personality Disorder
Substance Use (Please indicate current substances, amount, frequency of use, etc.):		
Any active substance use in the past 3 months?	Yes ☐	No ☐
Is there a history of substance use disorder?	Yes ☐	No ☐
If yes, please describe:		

Please fax all completed pages to 613-798-2973.

MEDICAL HISTORY		
Any past/current medical conditions/illnesses/disabilities?	☐ Yes	☐ No
If yes, please indicate include relevant reports and details (i.e. diagnosis, start date, has it been resolved – if yes, when? Any treatment or surgery received?):		
Allergies:		

CURRENT MEDICATIONS (both psychiatric and non-psychiatric)			
Medication Name	**Dose**	**Frequency**	**Response & Adverse Effects**

PAST MEDICATIONS (within current episode)			
Medication Name	**Dose**	**Frequency**	**Response & Adverse Effects**

PSYCHOTHERAPY		
Any psychotherapy in the current depressive episode?	☐ Yes	☐ No
☐ Cognitive Behavioral Therapy (CBT) ☐ Problem Solving Therapy	☐ Interpersonal Therapy (IPT) ☐ Other: _____	
If any have been checked off, please indicate details (dates, duration and outcome):		

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				

OTHER RELEVANT INFORMATION
Please indicate any other relevant information:

FAMILY PHYSICIAN/NURSE PRACTITIONER INFORMATION	
PATIENT DOES NOT HAVE FP/NP ☐	
Physician/Practitioner Name:	
Address:	
Telephone #:	
Fax #:	

REFERRING PROVIDER INFORMATION	
SAME AS ABOVE ☐	
Provider Name (Print):	
Billing #:	
CPSO #:	
Telephone #:	
Fax #:	

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)

Please attach any relevant documents and fax to the Neuromodulation Clinic at 613-798-2973 or e-mail to RTMS@theroyal.ca. *Note that incomplete forms will be returned.*

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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)

Please fax all completed pages to 613-798-2973.