



REFERRAL NEUROMODULATION PROGRAM (ECT/rTMS)

Desired Service: ECT rTMS

Admission Criteria: NOTE – INCOMPLETE FORMS NOT MEETING CRITERIA will be directed back to the referral source.

rTMS Note: At this time, HDGH is only utilizing rTMS treatment for diagnosis of Treatment Resistant Depression as defined by unresponsive trials of psychotherapy OR medication.

Does the client meet the definition of Treatment Resistant Depression? Yes No

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ (MM/DD/YYYY) Gender: Male Female Other

Health card Number: _____ Version Code: |_|_| Expiry Date: _____ (MM/DD/YYYY)

Address: _____

City: _____ Province: _____ Country: _____

Postal Code: _____

Phone Number: _____ Email: _____

Contact Person

Last Name: _____ First Name: _____

Phone Number: _____

Referring Physician

Physician: _____ OHIP Billing Number: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Office Phone Number: _____ Fax Number: _____

Pharmacy Contact Information: _____

Physician to Physician Contact Information: _____





Allergies: Latex Malignant hyperthermia Other: _____

Height: _____ cm Weight: _____ kg

DSM Diagnosis:

Goals for Treatment:

Target symptoms:

Method of tracking progress (how will you measure treatment response):

Presence of personality disorder/traits:

Medical Conditions:

- | | | |
|---|--|--|
| <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> anemia | <input type="checkbox"/> obstructive sleep apnea |
| <input type="checkbox"/> chronic pain/analgesia induced mood disorder | <input type="checkbox"/> substance induced mood disorder (including prescription psychotics/marijuana) | |

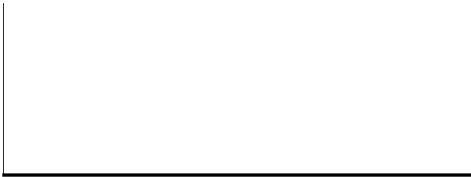
Other:

Current Medications including dosage, dates initiated and response (attach additional pages as necessary):

Current Herbals:

Current Over the Counter:





Past PSYCHIATRIC hospitalization: Yes No

Has this patient received ECT/rTMS treatment in the past? Yes No

Previous Course Dates	Unilateral/Bilateral	# of Treatments	Comments

Previous treatment for this disorder:
(Include all medications with duration, dosages and response, psychotherapy. Attach additional pages as necessary to include psychotherapy service provider information). rTMS requires a minimum of 1 unsuccessful medication trial OR 1 unsuccessful course of psychotherapy.

Is patient currently seeing a psychiatrist? If yes, who and how long?

Cautions/Notes to Psychiatrist administering ECT/rTMS:

Fax the completed forms to HDGH Neuromodulation Treatment Team: 519-257-5210

- The **referring provider will continue to care for the patient** for the duration of the ECT/rTMS treatment. The referring provider must work collaboratively with our treatment team during the treatment phase.
- ECT/rTMS has been explained by the referring physician and patient/SDM is in agreement to proceed with ECT/rTMS

I agree to abide by the above conditions.

Provider Signature

Date (MM/DD/YYYY)

Provider Name

