Parkwood Institute - Finch Family Mental Health Care Building
Therapeutic Brain Stimulations Clinic
550 Wellington Road, London ON, N6C 0A7
Mailing Address: P.O. Box 5777, STN B – London, ON N6A 4V2

Therapeutic Brain Stimulation Referral Form (ECT & rTMS)

Phone: 519-646-6100 x48727
Fax: 519-667-6811
E-mail: tbsclinic@sjhc.london.on.ca

Please separately fax OR confidentially email the following documentation along with this referral form prior to consult to help determine the best course of treatment for your patient at consultation.

***Please note** If approved for treatment, the rTMS psychiatrist will not be the MRP and will only be responsible for concerns related to rTMS treatment. The referring practitioner will remain responsible for patient follow ups and further care. *

REQUIRED documentation:

- ☐ Referral Form
- ☐ Current Medications
- ☐ Brief Medical History

Supplemental documentation if available:

- ☐ Psychiatric Assessment
- ☐ Medical Consult

Additional testing, assessments, or investigations may be required based on the patient's current health and health care needs. Please contact the TBS Clinic for more information.

Thank you!

Clinical Considerations and Contraindications

Absolute Contraindications/Clinical Exclusions – Treatment Not Permitted	**Yes**	**No**	**Unknown**
Ferromagnetic or metallic implants in the head or neck, such as aneurysm clips or coils, cochlear implants, stents, or cranioplasty plates. (Dental amalgams, fillings, crowns, and standard dental implants are permitted and do not require additional review.)			
Metallic foreign bodies in the head or neck, such as ocular metal shavings, shrapnel, or retained metallic fragments.			
Implanted electronic, programmable, or neurostimulation devices in the head or neck, such as a deep brain stimulator (DBS), vagus nerve stimulator (VNS), or programmable CSF shunt.			
Active or uncontrolled seizure disorder.			
Severe depressive disorder with psychotic features — consider referral for ECT.			
Bipolar disorder			
Severe personality pathology when this is the primary driver of the current presentation			
Acute suicidal or homicidal risk requiring an inpatient level of care.			
Relative Contraindications – Requires Clinical Review and Consultation			
Medical, Physiological, and Psychiatric Clinical Considerations			
Pregnancy or suspected pregnancy			
Significant head trauma or structural brain lesion, including a history of loss of consciousness, post-traumatic amnesia, intracranial hemorrhage, skull defect, or previous craniotomy.			
Cardiac pacemaker or implantable cardioverter-defibrillator (ICD)			
Other implanted electronic or programmable devices below the neck, such as an implanted medication or insulin pump.			
Facial or neck tattoos, microblading, or semi-permanent makeup located within 30 cm of the treatment coil or known or suspected to contain metallic pigment.			
Self-harm behaviour within the past six months.			
Medication Requirements			
Benzodiazepines: More than 2 mg/day lorazepam equivalent			
Bupropion: No more than 300 mg/day, both currently and during the preceding week.			
Monoamine oxidase inhibitors (MAOIs): current use			

Referral Form: **Therapeutic Brain Stimulation Clinic (ECT & rTMS)**	
Patient Information	
Last Name:	**Status** (*if applicable*)**:**

First Name(s):		☐ Veteran ☐ CF Member ☐ RCMP
Street Address:	**City:**	**Postal Code:**
Phone Number 1: **Phone Number 2:** **Email Address:**		**Health Card Number and Version Code:**
Date of Birth (YY/MM/DD):	**Age:**	**Blue Cross Number** (*if applicable*)**:**
☐ **Inpatient** ☐ **Outpatient**		**Hospital and Ward:** **PIN / RL Number:**

Patient Medical Information

Capable of Consent: ☐ Yes or ☐ No	**Substitute Decision Maker Information** (*if patient is incapable of consent*): Name: Phone Number:

Primary Psychiatric Diagnoses: 1) _____ 2) _____ 3) _____	**Comorbid Psychiatric Diagnoses** (*include personality disorders and substance abuse)*: 1) _____ 2) _____ 3) _____
Medical Diagnosis + Stability: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	**Considering:** ☐ TMS ☐ ECT **Check all reasons that apply for consideration:** ☐ Prior effective ECT ☐ Prior effective TMS ☐ One failed adequate antidepressant trial ☐ Two failed adequate antidepressant trials from different drug classes ☐ Failure of combination/augmentation strategies ☐ Failure of psychotherapy in combination with antidepressants

REQUIRED: Please provide a short narrative of the reason for referral

*** Please include recent assessment/ consult notes ***

Referring Practitioner Information	
Name:	**Phone Number:** **Extension:**
Title/Discipline:	**Fax Number:**
Organization:	**Email:**
Will continue to monitor and follow up with patients during and after treatments? ☐ Yes ☐ No **Explain Alternatives:**	

Practitioner's Signature _____ **Referral Date (yy/mm/dd):** _____