Please Review with Client and Provide Document to Client

Electronic Communications: Client Information Sheet

Unity Health Toronto (St. Michael's Hospital, St. Joseph's Health Centre, and Providence Healthcare) would like to communicate with you by email or text. You may also want us to email or text a loved one or a person involved in supporting your care. We need your permission to do so.

Basic Information - General health information and hospital announcements only

Only your health condition and appointment information will be sent. This may include:

- Information about your appointments:
  - The time and date of your appointment,
  - The name of your care provider or clinic, and
  - The location of the clinic or office (for in-person visits), the phone number to call (for phone visits), or the link to use (for video visits), and
  - The wait time for your appointment
- Links to sign up for patient portals
- Links to surveys about your experience at the hospital
- Questions for research about your experience at the hospital
- General information about your disease or condition (such as newsletters from the clinic or educational materials)
- General hospital announcements and clinic announcements
- General changes to clinic policies

If you have questions…

If you have any questions, or if you change your mind, please contact your doctor, care team, or Patient Registration as soon as possible. For questions or concerns about your privacy, please visit our website at https://unityhealth.to/protecting-your-privacy/

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FREQUENTLY ASKED QUESTIONS

What do I need to know about emails and texts?

Emails and text messages are not protected in the same way that phone calls and letter mail are protected. This means that if someone sees the texts or emails, they may know that you are a patient at Unity Health Toronto. They may also see any other information shared in the email or text message.

- Emails and texts may be read or saved by your internet or phone provider (such as Rogers).
- There is always a chance that an email could be read by others, or changed without you knowing.
- Emails can contain a virus that can harm your computer.
- If your phone is lost or stolen, text messages could be read by others.

Is email and text communication optional?

Yes. Email and text communication are not required. If you decide that you do not want to communicate in this way, the hospital will continue contacting you by telephone or regular mail. If you chose not to email or text, your care will not be affected.

Can I change my mind about email and text?

Yes. You can change your mind about email and text communication at any time by contacting your doctor or care team.

How does Unity Health Toronto protect my information?

- Your phone number and email address are kept secure in our systems.
- Any information that you send us may be added to your record if it is important for your care.
- Your email may be shared with other hospital staff if it is needed for your care, to run the Hospital, or for another reason that the law allows.

Can I use text or emails for an emergency?

No, emails sent to the hospital may not be read right away. **Do not send text messages or email for medical emergencies**. If you need immediate help, call your clinic or health care provider, or go to the Emergency department.

What else do I need to do?

Check your emails and text messages regularly. Tell the hospital if you or your loved one changes phone numbers or email addresses.

IMPORTANT: Unity Health Toronto will never ask patients or families to send personal identifiers by text message or email (OHIP number, hospital number, or address). If you get a text message or email asking for this information, please do not respond. This may be a harmful message.

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Referral Form for Neurostimulation Clinic - rTMS

Location: St. Joseph's Health Centre, 30 Queensway, 5th Floor Gilgan Toronto, ON

Phone Number: 416-530-6591 **Fax:** 416-530-6076 **Email:** rTMSclinic@unityhealth.to

INFORMATION FOR REFERRING PRACTITIONER:

- **A Family Practitioner, Nurse Practitioner (FP/NP) or Psychiatrist referral is required** (self-referral is not accepted)
- The referring provider **must provide concurrent care during the time limited treatment offered within the Neurostimulation Clinic**
- This referral form is for the NeuroStimulation Clinic only at St. Joseph's Health Centre

INFORMATION FOR THE PATIENT BEING REFERRED:

- Please ensure that your **patient consents to the referral** being made
- Please ensure that your patient is aware that **services are time-limited and they must be able to complete their entire treatment** (daily for up to 6 weeks) **at St. Joseph's**
- Our intake team will make **two attempts to contact the patient** and leave two voicemails, when consent is provided. If the patient cannot be reached, the referring provider will be notified.
- Given SJHC is a teaching hospital, your patient can expect to have residents or other learners involved in their care.
- Given SJHC is part of an academic research network, your patient may be invited to participate in research opportunities. They do not need to accept.

PLEASE NOTE THE FOLLOWING CRITERIA:

Referral will be accepted if the following criteria are met:

- Patient has a diagnosis of **Major Depressive Disorder or Bipolar Affective disorder, current episode depressed**
- Patient has failed at least **one or more guideline concordant medication trials in the current episode of depression**
- Referring provider agrees to provide concurrent care during the time limited course of treatment. No additional psychiatric follow-up will be provided once treatment is completed.
- Patient accepts that treatment and services are time-limited
- Patients **must** be able to complete the full treatment course at St. Joseph's
- 18 years of age or older

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PATIENT INFORMATION:

Consented to referral and has been informed serviced are time-limited? ☐ Yes ☐ No

Legal Full Name: _____ Preferred Name: _____

Date of Birth: _____ PRONOUN: _____

Address: _____ ☐ *No Fixed Address*

Postal Code: _____

Health Card Number: _____ Version Code: _____

Telephone Number: _____ Alternative Phone Number: _____

Consent to Leave Voicemail:

Consent to leave message with another person?

If yes, specify who and patient's relationship: _____

If your patient would like to use e-mail for appointments, scheduling, indicate the following has been completed:

☐ Received & Reviewed St. Joseph's Health Centre email consent with patient

☐ Included Signed E-mail Consent with referral

FAMILY PHYSICIAN/NURSE PRACTITIONER INFORMATION: ☐ PT DOES NOT HAVE FP/NP

Name:	Telephone:
Address:	Fax #:
E-mail Address:	

REFERRING PROVIDER INFORMATION: ☐ SAME AS ABOVE

Referring Provider Name/Designation (Print):_____

Billing #: _____ CPSO #:_____

Phone #: _____ Fax #:_____

Signature: _____ Date of Referral: _____

REASON FOR REFERRAL (Please include most recent consultation and/or discharge):

Please indicate primary reason for referral, current symptoms, and provide details of prior treatments:

PAST PSYCHIATRIC HISTORY (Please include discharge summaries):

PAST MEDICATION TRIALS (You may also attach a list of previous medications):

☐ Amitriptyline	☐ Duloxetine	☐ Milnacipran	☐ Sertraline
☐ Aripiprazole	☐ Escitalopram	☐ Mirtazapine	☐ Thyroxine
☐ Brexpiprazole	☐ Fluoxetine	☐ Moclobemide	☐ Tranylcypromine
☐ Bupropion	☐ Fluvoxamine	☐ Nortriptyline	☐ Trazadone
☐ Buspirone	☐ Imipramine	☐ Olanzapine	☐ Trifluoperazine
☐ Citalopram	☐ Isocarboxazid	☐ Phenelzine	☐ Triiodothyronine
☐ Clomipramine	☐ Levomilnacipran	☐ Quetiapine	☐ Venlafaxine
☐ Desipramine	☐ Lithium	☐ Risperidone	☐ Vilazodone
☐ Desvenlafaxine	☐ Lurasidone	☐ Selegiline	☐ Vortioxetine
☐ Doxepin	☐ Paroxetine	☐ Other:	

PAST INTERVENTIONAL/EXPERIMENTAL TREATMENT TRAILS:

Please select all relevant trials and include details (date, duration, and outcome)

☐ Repetitive Transcranial Magnetic Stimulation_____
☐ Electroconvulsive Therapy _____
☐ Deep Brain Stimulation_____
☐ Ketamine_____
☐ Other (please specify)_____

PAST PSYCHOTHERAPY TRIALS:

Please select all relevant trials and include details (date, duration, and outcome)

☐ Cognitive Behavioral Therapy_____
☐ Mindfulness Based Therapy_____
☐ Interpersonal Therapy_____
☐ Dialectical Behavioral Therapy_____
☐ Psychodynamic Therapy_____
☐ Other: _____

CURRENT MEDICATIONS (List ALL medications including DOSE and FREQUENCY):

Medication	Dose	Date	Outcome

ALLERGIES:

MEDICAL HISTORY (Please include relevant reports):

SUBSTANCE USE (Please indicate current substances, amount, frequency of use, etc.):

Is there any active substance use in the last 3 months? ☐ **Yes** ☐ **No**

Is there a history of substance use disorder? ☐ Yes ☐ No

If yes, please describe:_____

_____

RISK & SAFETY CONCERNS:

This information is used to optimally plan for the patient's first appointment and to ensure their safety and their safety of our staff

RISK ISSUES	PRESENT		PAST		DETAILS
	YES	*NO*	*YES*	*NO*	
Criminal Charges	☐	☐	☐	☐	
Violent Behavior	☐	☐	☐	☐	
Suicide Attempt(s)	☐	☐	☐	☐	
Other Self-Harm Behavior	☐	☐	☐	☐	
ADDITIONAL COMMENTS:					

Please attach any relevant documents and fax to Neurostimulation Clinic at **416-530-6076** or email to **rTMSclinic@unityhealth.to**

Please note that incomplete/illegible forms will be returned