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.

ST. JOSEPH'S UNITY HEALTH TORONTO

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Referral Form for Neurostimulation Clinic – rTMS Referral Form

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

Phone Number: 416-530-6591 **Fax:** 416-530-6076 **Email:** CCC@stjoestoronto.ca

INFORMATION FOR REFERRING PRACTITIONER:

- **A Family Physician or Psychiatrist referral is required** (self-referral is not accepted)
- **At this time only patients within SJHC catchment will be accepted for treatment**
- The referring physician **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**
- 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 physician agrees to provide concurrent care during the time limited course of rTMS treatment. No additional psychiatric follow-up will be provided once treatment is completed.
- Patient accepts that treatment and services are time-limited
- 18 years of age or older
- Lives within the **catchment area**

M6E, M6H, M6K, M6M, M6N, M6P, M6R, M6S, M6S, M8V, M8X, M8Y, M8Z, M9A

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Referral completed by: ☐ Family Physician (FP) ☐ Psychiatrist (Please provide FP information below)

FAMILY PHYSICIAN INFORAMTION:

Name:	Telephone:
Address:	Fax #:
E-mail Address:	☐ Patient Does not have FP

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

PLEASE SELECT SERVICE THIS REFERRAL IS INDICATED FOR:

Repetitive transcranial magnetic stimulation	☐ Inpatient	☐ Outpatient

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

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

Please complete the screening tools attached below:
PHQ-9 score: GAD-7 score: Completed C-SSRS (Y/N): Completed TASS (Y/N):

PAST PSYCHIATRIC HISTORY:

HOSPITALIZATIONS (Please include discharge summaries) & AGENCIES (Last 2 years)

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

Medication	Dose	Date	Outcome

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
☐ Dialectical Behavioral Therapy	☐ Cognitive Processing Therapy
☐ Interpersonal Therapy	☐ Psychodynamic Therapy
☐ Other:	

CURRENT MEDICATION TRIALS (Lis 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:					

_____
Referring Physician Name & Designation (Print)

_____
Billing #

_____
Tel #

_____
Fax #

_____
Email

_____
Address

_____
CPSO #

_____
Signature

_____
Date of Referral

*Please attach any relevant documents and Fax to Neurostimulation Clinic to: 416-530-6076 or email-completed referral with scales to **CCC@stjoestoronto.ca***

Please note that forms that are incomplete or not clearly printed will be returned.

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Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____Patient Name:_____Date of Birth: _____

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not Difficult at all **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not Difficult at all **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

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Neurostimulation Clinic: TMS Adult Safety Screen (TASS)

Required to be completed by referred patient

	YES	NO	
1	☐	☐	Have you undergone TMS in the past?
2	☐	☐	Do you have epilepsy?
3	☐	☐	Have you ever had a convulsion or a seizure? If yes, please describe:
4	☐	☐	Does anyone in your family have epilepsy?
5	☐	☐	Have you ever had a fainting spell or syncope? If yes, please describe the occasion(s):
6	☐	☐	Have you ever had a stroke?
7	☐	☐	Have you ever had a head injury? If yes, was this associated with a concussion or loss of consciousness? Please describe:
8	☐	☐	Have you ever had neurosurgery? If yes, please specify:
9	☐	☐	Have you had any illness that caused brain injury? If yes, please specify:
10	☐	☐	Do you have metal in the brain, skull or elsewhere in your body such as shrapnel, surgical clips, splinters or fragments from welding or metalwork? If yes, please specify position and type of metal:
11	☐	☐	Do you have a cardiac pacemaker or intracardiac lines?
12	☐	☐	Do you have a medication infusion device? If yes, please specify:
13	☐	☐	Do you have an implanted neurostimulator? (e.g., DBS, epidural/subdural, VNS) If yes, please specify:
14	☐	☐	Do you have any hearing problems or ringing in your ears?
15	☐	☐	Do you have cochlear implants?
16	☐	☐	Do you suffer from frequent or severe headaches?
17	☐	☐	Have you ever had any other brain-related condition?
18	☐	☐	Have you ever had an electroencephalogram (EEG)? If yes, what was the reason?
19	☐	☐	Have you ever undergone MRI in the past? If yes, were there any issues?
20	☐	☐	Are you pregnant or is there any chance that you might be?

	YES	NO	
21	☐	☐	Over the last 12 months, how many standard alcoholic drinks would you drink in an average week? (1 standard drink is 100mls of wine, 30mls spirits, 1 mid strength beer) **If yes, please specify all:**

Type: Amount: Frequency:	Type: Amount: Frequency:
Type: Amount: Frequency:	Type: Amount: Frequency:
Type: Amount: Frequency:	Type: Amount: Frequency:

I CONFIRM that, to the best of my knowledge, the above responses are accurate.
If there are any changes, I will inform the rTMS Psychiatrist.

DATE	**TIME (24 h)** _ _ : _ _ h	_____ **PATIENT SIGNATURE**	**PRINT PATIENT NAME**

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Screen Version/ Since Last Contact

Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*	☐	☐
2) *Have you actually had any thoughts of killing yourself?*	☐	☐
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"	☐	☐
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"	☐	☐
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*	☐	☐
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***	**YES** ☐ ☐	**NO** ☐ ☐

	Low Risk
	Moderate Risk
	High Risk