Eastern Health

Mental Health and Addictions Program

Repetitive Transcranial Magnetic Stimulation (rTMS) Referral (Part I)

Send referral documents to: RTMS.Forms@easternhealth.ca

Fax: 709-777-2794

CL2360 2450 03 2024

Name:

HCN:

Date of Birth:

ALLERGIES: ☐ No Known

Patient's age:_____(must be 18-65 years of age) Weight:_____kg (maximum rTMS chair weight is 150kg or 330 lbs)

Indication for rTMS, Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnoses:_____

rTMS history: ☐ Yes ☐ No

If Yes, specify (including response to treatment and side/adverse effects or complications): _____

Electroconvulsive therapy history: ☐ Yes ☐ No

If Yes, specify (including response to treatment and side/adverse effects or complications): _____

Did the patient have a Magnetic Resonance Imaging (MRI): ☐ Yes ☐ No

Did problems occur during scanning: ☐ Yes ☐ No If Yes, specify: _____

Potential contraindication to rTMS (elaborate in the medical history section if Yes is checked to any of the following:	**Yes**	**No**
History of seizure, convulsion, epilepsy or electroenecphalogram (EEG)	☐	☐
Family history of seizure or epilepsy	☐	☐
History of syncopal or fainting episode	☐	☐
History of stroke, transient ischemic attack	☐	☐
History of loss of consciousness or concussion	☐	☐
History of head, brain, spinal injury or trauma (including surgery)	☐	☐
History of head, brain, spinal or neurological (including congenital) illness, infection, deviation, malformation, lesion or tumor, frequent or severe headache or increased intracranial pressure (ICP))	☐	☐
History of cardiac disease (including arrhythmia)	☐	☐
Suspected or diagnosed labile hypertension	☐	☐
Hearing loss or limitation, ringing in ears, tinnitus or hearing aid	☐	☐
Electronic, magnetic or metal implant or prosthesis (heart valve, ear, eye or dental implant, eyelid spring or wire, surgical clip, screw, coil, plate, stent, suture, staple, filter or shunt) (exception dental work in the mouth)	☐	☐
Electronic or magnetic device or electrodes (pacemaker, internal or wearable defibrillator, cardioverter, intracardiac line, medication pump, brain, neurological, cranial, peripheral, epidural, spinal or vagus nerve stimulator or cochlear implant)	☐	☐
Injury by a metal object or foreign body (fragment, sliver, splinter, shrapnel, BB or bullet) or a welding/metal worker	☐	☐
Head, scalp or facial tattoos with metallic or magnetic-sensitive ink	☐	☐
Wear metal dentures	☐	☐

Note: Magnetic, electric or metal devices, implants and objects must not be within 30 centimeters (12 inches) of the treatment coil or in or near the head.

Referring Psychiatrist's Name:_____ Contact Number: _____

Signature: _____ Date: _____DD/MONTH/YYYY_____

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Repetitive Transcranial Magnetic Stimulation (rTMS) Referral (Part II)

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Name:

HCN:

Date of Birth:

Other mental health history (including secondary DSM-5 diagnosis):

Note: Medication history (patients must be on a stable medication regimen for at least 4 weeks before starting rTMS. Anticonvulsants, GABAergics, including Benzodiazepines may interfere with treatment efficacy and should be decreased or discontinued at least 4 weeks prior to the treatment start date). List all medications, as many prescriptions and over the counter medications lower seizure threshold (increasing the risk of a seizure).

Change in medications in the last 4 weeks: ☐ Yes ☐ No If Yes, specify:

Bupropion: ☐ Yes ☐ No If Yes specify: (exclusion criteria if the prescribed daily dose is more than 300 mg currently or in the past week)

Monoamine Oxidase Inhibitor (MAOI): ☐ Yes ☐ No If Yes, specify: (exclusion criteria if MAOI taken currently or in the last four weeks)

Antidepressant trial, dose details and duration (symptoms must have failed to improve with 2 antidepressant trials of adequate dose and duration):

GABAergics: ☐ Yes ☐ No If Yes, specify:

Anticonvulsant: ☐ Yes ☐ No If Yes, specify:

Benzodiazepine: ☐ Yes ☐ No If Yes, specify (must be less than 2 mg of lorazepam equivalent per day):

Antihistamines (including over the counter): ☐ Yes ☐ No If Yes, specify:

Current antibiotic use: ☐ Yes ☐ No If Yes, specify:

Other Medications	Dosage - may include a list with referral

Referring Psychiatrist's Name: Contact Number:

Signature: Date: DD/MONTH/YYYY

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Mental Health and Addictions Program

Repetitive Transcranial Magnetic Stimulation (rTMS) Referral (Part III)

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Name:

HCN:

Date of Birth:

Current caffeine use: ☐ Yes ☐ No If Yes, specify (frequency/amount): _____

Current alcohol use: ☐ Yes ☐ No If Yes, specify (frequency/amount): _____

Drug use concerns: (legal medications or marijuana or illegal substances including cocaine, ecstasy, inhalants, phencyclidine, amphetamines, psychostimulants, etc.): ☐ Yes ☐ No If Yes, specify (frequency/amount): _____

_____

Other substance use history: ☐ Yes ☐ No If Yes, specify (frequency/amount): _____

_____

History of electrolyte disturbance: ☐ Yes ☐ No If Yes, specify: _____

_____

Problems with sleep: (less than 4 hours a night): ☐ Yes ☐ No If Yes, specify: _____

_____

Chance of pregnancy: ☐ Yes ☐ No If Yes, specify: _____

_____

History of Temporomandibular Joint, Trigeminal Neuralgia, tremors or neck pain: ☐ Yes ☐ No If Yes, specify: _____

_____

Other medical and surgical history and treatments (the patient must be medically stable): _____

_____

_____

_____

_____

Access or compliance barriers (treatment plan 5 days a week for 6 weeks): ☐ Yes ☐ No If Yes, specify: _____

_____

Unaddressed psychosocial or situational stressors (barrier to treatment efficacy): ☐ Yes ☐ No If Yes, specify: _____

_____

Current psychotherapies: _____

_____

Additional information:

_____

_____

_____

_____

_____

Referring Psychiatrist's Name: _____ Contact Number: _____

Signature: _____ Date: DD/MONTH/YYYY

Eastern Health

Mental Health and Addictions Program

Repetitive Transcranial Magnetic Stimulation (rTMS) Referral (Part IV)

Send referral documents to: RTMS.Forms@easternhealth.ca

Fax: 709-777-2794

CL2360 2450 03 2024

Name:

HCN:

Date of Birth:

Additional information continued:

Patient provided with Repetitive Transcranial Magnetic Stimulation patient handbook: ☐ Yes ☐ No

Note: Use consultation record (Ch-0092), if additional documentation is required.

Note: Patient care for non-rTMS matters must be continued by the referring Psychiatrist during the rTMS course.

Referring Psychiatrist's Name: _____ Contact Number: _____

Signature: _____ Date: DD/MONTH/YYYY