Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE

500 Church Street, Penetanguishene ON L9M 1G3
500, rue Church, Penetanguishene (Ontario) L9M 1G3
705-549-3181 www.waypointcentre.ca

# Waypoint Centre for Mental Health Care
# Transcranial Magnetic Stimulation (TMS) Referral

If you have any questions about the referral process, please call Waypoint Centre for Mental Health Care's Central Intake department at **705-549-3181 ext. 2308**.

Visit our website for more information regarding TMS.

**Referral Requirements – a referral cannot be processed without the following:**

1. **Physician / Nurse Practitioner – referral is required for Transcranial Magnetic Stimulation**
2. **Eligibility Criteria:**
   Age: over 18 years old.
   Diagnosis: confirmed major depressive disorder or bipolar affective disorder, currently experiencing a depressive episode without psychotic features.
   Previous Treatment: unsuccessful treatment with at least one antidepressant medication.
   Ongoing Care: must have an ongoing relationship with a primary care provider or psychiatrist for the duration of the treatment.
3. **Exclusion Criteria (patient is not suitable for deep TMS if they have any of these):**
   Seizure Disorders: individuals with a history of seizure disorders.
   Pregnancy: currently pregnant, breastfeeding, or planning to become pregnant during the treatment period.
   Patients with metal in or around the head, including metal plates, aneurysm coils, cochlear implants, ocular implants, deep brain stimulation devices, and stents.
   Patients with implants controlled by physiological signals, including pacemakers, implantable cardioverter defibrillators, and vagus nerve stimulators.
   Patients who have a suicide plan or have recently attempted suicide.
   Lack of Primary Care: absence of a primary care provider or psychiatrist to oversee treatment.
   Commitment: inability or unwillingness to commit to a minimum of 6 weeks of treatment.

**Please send the completed Referral Form and all supporting documents to Waypoint Centre for Mental Health Care Central Intake by fax to 705-549-1812 or by email to centralintake@waypointcentre.ca.**

**We cannot begin processing the referral without a completed Referral Form and all supporting documentation.**

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# Waypoint Transcranial Magnetic Stimulation Referral

| FOR WAYPOINT USE ONLY | Date Received: | | Account #: | |
|---|---|---|---|---|

## Client/Patient Information

| | | | | | |
|---|---|---|---|---|---|
| Name (last name, first name): | | | | | |
| DOB *(dd/mm/yyyy)*: | | Preferred Name: | | | |
| Address: | | City: | | Postal Code: | |
| Primary Telephone #: | | Alternate Phone #: | | | |
| Gender: | Female | Trans (male to female) | Intersex | Two Spirit | |
| | Male | Trans (female to male) | Other (please specify): | | |
| Health Card Number: | | Version Code: | | Expiry Date: | |
| Does the patient/client self-identify as: | First Nations | Inuit | Métis | Urban Indigenous | |

## Referral Source Information

| | | | |
|---|---|---|---|
| Referring Physician: | | Telephone #: | |
| Referring Physician's OHIP Billing Number: | | | |
| Consent obtained: Yes No | | Substitute Decision Maker: | |
| **Referring Physician's Signature:** | | | |

***Your submission of this referral form will be taken to explicitly mean that you have obtained appropriate permissions for releasing the information contained in this referral form to Waypoint Centre for Mental Health Care (the agencies) and Services to whom you are submitting this referral form. If applicable, please include your Organization's Consent to Release of Personal Health Information Form.***

## Referral Information

**Current Psychiatric Diagnosis:**

**History of Psychiatric Illnesses – severity of symptoms, prior treatment, and response to those treatments:**

**Current Mental Status:**

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| **Has patient previously received TMS:** Yes No | **Hospital:** | | |
|---|---|---|---|
| **If yes, which type:** | | **# of Treatments:** | |
| **Over what period of time:** | | | |

**Medical Diagnoses and Problems:**

**Risk of Harm (self and / or others):**

**Medical, Addictive, and Psychiatric Comorbidity:**

**Current Stressors:**

**Engagement and Recovery Status:**

## Medication List

Include prescription, vitamins, over the counter medications, and herbal supplements

| Medication | Dose/Units | Route | Frequency | Instructions/Comments |
|---|---|---|---|---|
| See attached Medication List / copy of Medication Administration Record | | | | |
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