|  |
| --- |
| **Waypoint Centre for Mental Health Care Electroconvulsive Therapy (ECT) Referral**  |
| If you have any questions about the referral process, please call Waypoint Centre for Mental Health Care Central Intake at **705-549-3181, ext.2308**. Visit our [website](http://www.waypointcentre.ca/programs_and_services) for more information regarding Electroconvulsive Therapy (ECT), including indications for ECT. |
| **Referral Requirements** – a referral cannot be processed without the following: 1. **Physician/nurse practitioner** –referral is required for Electroconvulsive Therapy (ECT).
2. **Patient must have one of the four primary indications for ECT:**

[ ] *Major Depressive Episode* (arising from unipolar depression, as part of bipolar depression, or concomitant manic symptoms during “mixed states”) associated with one of the following features:* + - [ ]  Acute suicidality with high risk of acting out suicidal thoughts
		- [ ]  Psychotic features
		- [ ]  Rapidly deteriorating physical status due to complications from the depression, such as poor oral
		- intake
		- [ ]  History of poor response to medications
		- [ ]  History of good response to ECT
		- [ ]  Patient preference
		- [ ]  Risks of standard antidepressant treatment outweigh the risks of ECT, particularly in medically
		- frail or elderly patients
		- [ ]  Catatonia

[ ] *Mania:*any of the features of Major Depressive Episode are present with one of the following[ ] Extreme and sustained agitation[ ] The presence of “manic delirium”[ ] *Schizophrenia*[ ] Positive symptoms with abrupt or recent onset[ ] Catatonia[ ] *Self-Injurious Behaviour and Aggression Associated with Intellectual Disability*1. **Psychiatric Diagnosis, Current Symptoms, and Psychiatric History** – including psychiatric medication trials
2. **Medical/Problem Diagnosis** – list of medical diagnoses/problems including Diagnostic Indications
3. **Most Recent Cardiology Consultation Report** – if patient has a history of cardiac conditions
4. **Most Recent Neurology Consultation Report** – if patient has a history of neurological conditions
5. **Current Medications**
6. **Risk Identification** – at the time of the referral the patient risks are documented
7. **Labs and Diagnostics** – recent and relevant lab work as well as diagnostic reports
8. **Consultations** – psychiatric and other relevant consultations and discharge summaries
 |
| **\*\*\*Please send the completed Referral Form and all supporting documents to Waypoint 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.** |

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

|  |  |
| --- | --- |
| Last name, first name:  |  |
| DOB *(dd/mm/yyyy)*: |  |
| Address:  |  |
| Contact Numbers: |  |
| Gender: [ ]  Female [ ]  Male [ ]  Intersex [ ]  Trans (male to female) [ ]  Trans (female to male) [ ]  Two Spirit [ ]  Other:  |
| Health Card number:  | Version Code: |  | Expiry date: |  |
| Print Referring Physician’s Name: |  |
| Referring Physician’s Signature: |  |
| Telephone Contact Information: |  |
| Consent obtained: | [ ]  Yes [ ]  No | Substitute Decision Maker: |  |
|  |
| Current Psychiatric Diagnosis: |
| History of Psychiatric Illnesses – severity of symptoms, prior treatment, and response to those treatments: |
| Current Mental Status: |

|  |  |
| --- | --- |
| Has patient previously received ECT?: [ ]  Yes [ ]  No | Hospital: |
| If yes: [ ]  Unilateral [ ]  Bilateral | Number of Treatments: |
| Over what period of time: |

|  |
| --- |
| Diagnostic Indications:[ ]  Cardiac Arrhythmia [ ]  Increased Intracranial Pressure[ ]  Electrophysiological Abnormality [ ]  Brain Neoplasm[ ]  Pacemaker [ ]  Seizure Disorder[ ]  Stroke [ ]  Asthma/COPD/Respiratory Illness[ ]  Aortic Aneurysm [ ]  Pheochromocytoma |
| Medical Diagnoses and Problems: |
| Risk of Harm (self and/or others): |
| Medical, Addictive, and Psychiatric Co-morbidity: |
| Current Levels of Stressors: |
| Engagement and Recovery Status: |
| Is patient pregnant: [ ]  Yes [ ]  No Recent Obstetrical Consult: [ ]  Yes [ ]  No Date: |

|  |
| --- |
| **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 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |