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| **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**](mailto:centralintake@waypointcentre.ca)**.**  **We cannot begin processing the referral without a completed Referral Form and all supporting documentation.** |

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

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| 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: | | |  | | |
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| 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 ECT?:  Yes  No | Hospital: |
| If yes:  Unilateral  Bilateral | Number of Treatments: |
| Over what period of time: | |

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| 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: |

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| **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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