

Privacy Policy

Purpose for Collection and Use of Personal Health Information (PHI)

We collect, use, and disclose PHI only for the purposes of identifying the appropriate service needs as well as:

- Collecting relevant information contained in the records maintained by the organizations associated with The Access Point Northwest.
- Making referrals to the associated agencies for services, and to fulfill other purposes required or permitted by law.
- Sending this application to any agencies that will be providing services.
- Disclosing the PHI to a person or organization other than those associated without consent in limited circumstances required by law, such as emergencies of child welfare concerns.
- Use of de-identified PHI about applicants to plan and deliver services, for program evaluation, for statistical purposes, and for reporting to our funders.

Privacy Officer

If there are any questions or concerns about privacy, please contact our Privacy Officer with The Access Point Northwest at (807)-683-8200. If there are still concerns, please contact the Office of the Information and Privacy Commissioner at 1400-2 Bloor St E, Toronto, ON M4W 1A8, (416) 326-3333.

Referral Process

Please fill out all included pages. To withdraw the application, please contact (807) 624-3465.

The following referrals can only be completed by the primary care provider or someone willing to act as the most responsible provider (MRP):

_____ (Billing or College Number)

Regional Transcranial Magnetic Stimulation.

By applying to this service, you agree to the following criteria:

- | | |
|--|---|
| <ul style="list-style-type: none"> • If approved for treatment, the rTMS psychiatrist will not be the MRP and will only be responsible for concerns related to rTMS treatment • Voluntary status (if they are an inpatient) • No history of seizures • No history of psychosurgery or deep brain stimulator • No history of brain injury with loss of consciousness > one hour or more • No severe Axis II diagnosis • Clients/patients receiving benzodiazepines should be on less than or equal to the equivalent of 2 mg of lorazepam per day • Have received continuation and maintenance convulsive therapy to prevent relapse and efforts to reduce or stop convulsive therapy have been unsuccessful | <ul style="list-style-type: none"> • No Monoamine Oxidase Inhibitor (MAOI) antidepressant medication taken currently or in the past four weeks • No active suicidal/homicidal ideation • No history of self-harm behavior in the last 6 months • No metal head plates, cochlear implants or pacemakers • No Bupropion prescribed at a daily dose greater than 300 mg currently or in the past week • Not pregnant • Had a good response to convulsive therapy and cannot tolerate or attend for continuation or maintenance convulsive therapy |
|--|---|

Declaration and Consent

- I have done my best to ensure that all information provided on this application is correct.
- I have discussed this application with the applicant and obtained the applicant's knowledge and voluntary consent to make this referral.
- The applicant consents to the collection, use, and disclosure of the personal health information provided.
- The applicant understands that the personal health information provided on this application may be shared by relevant agencies included with The Access Point Northwest.
- The applicant consents to The Access Point Northwest to access medical records relevant to this application.
- The applicant consents that if the application is not accepted, it can be forwarded to a program outside The Access Point Northwest.

Name of Referrer: full name with credentials

Agency/Department: _____

Contact Number: _____

Fax Number: _____

Contact Information (paste label over top of this section)

First/Given Names(s): _____ Last Name: _____
 Address: _____
 Phone Number: _____ Can leave message? Yes No
 Alternate Number: _____ Can leave message? Yes No
 Email: _____ Preferred Language: _____
 Date of Birth: _____ month / day / year Health Card #: _____
 Gender: Female Male Other Indigenous? Yes No
 Indigenous Service Preferred? Yes No

Medical Contact

Does the applicant **have a primary care provider** (physician or nurse practitioner)? Yes No
 Name: _____ Agency/Clinic: _____
 Phone Number: _____ Fax Number: _____

Existing Supports

If the applicant is currently working with any **other service providers**, please list below:

Agency 1: _____ Agency 2: _____
 Contact Name: _____ Contact Name: _____
 Contact Number: _____ Contact Number: _____

Does the applicant have access to an **Employee Assistance Program**? Yes No
 Has the applicant been referred for **other mental health programs**? Yes No

Reason for the Referral

Please briefly describe the **reason(s) for the referral**, including any **clinical questions, diagnoses, description of symptoms, requested services, support needs, etc.**

Primary Symptom: _____ Secondary Symptom: _____

Medication Review

If the applicant is **currently taking ANY medications**, please indicate below, or attach a medication list.
Please note:

- All patients must be on a stable medication regimen for at least 4 weeks prior to treatment.
- Anticonvulsants may interfere with rTMS and should normally be discontinued 4 weeks prior to treatment.
- Benzodiazepines have been shown to interfere with rTMS. Patients must be on less than 2mg equivalent of lorazepam or discontinued completely 4 weeks prior to treatment.

Medication	Dosage\Frequency

Select if the applicant has had any of the following:

- | | |
|---|--|
| <input type="checkbox"/> History of epileptic seizures
<input type="checkbox"/> Family history of epilepsy
<input type="checkbox"/> History of syncopal episodes
<input type="checkbox"/> Head trauma with loss of consciousness
<input type="checkbox"/> Cardiac disease
<input type="checkbox"/> Cardiac arrhythmia
<input type="checkbox"/> Implanted cardiac pacemaker
<input type="checkbox"/> Implanted DBS or other neuro-stimulator
<input type="checkbox"/> Cochlear implant | <input type="checkbox"/> Medication infusion device
<input type="checkbox"/> Aneurysm clip or coils
<input type="checkbox"/> Metallic implant or other foreign body
<input type="checkbox"/> Dental implants
<input type="checkbox"/> Metal fragments in eye or history of metalwork
<input type="checkbox"/> History of spinal surgery
<input type="checkbox"/> Impairment of vulnerability of hearing
<input type="checkbox"/> Pregnancy
<input type="checkbox"/> History of alcohol or drug abuse |
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Additional Information

Please attach any relevant consult letters, test results, or other pertinent medical records.