Sunnybrook
HEALTH SCIENCES CENTRE

FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE

Website: www.sunnybrook.ca/thompson
Phone: 416-480-4002 Fax: 416-645-0592
Email: ThompsonCentreClinic@sunnybrook.ca

Residential or Day Treatment Supplementary Referral Form

Dear Referring Provider,

Welcome and thank you for considering the Frederick W. Thompson Anxiety Disorders Centre for treatment for your patient's obsessive compulsive disorder (OCD). Our Centre specializes in the treatment of OCD and related "spectrum" disorders, including hoarding, hair pulling (trichotillomania), skin picking and body dysmorphic disorders.

The following **must be submitted** as part of the residential / Day treatment referral (please submit all items at once):

- ☐ Physician Referral Form – to be completed by the referring physician (GP, psychiatrist or nurse practitioner)
- ☐ Form A
- ☐ Thompson Centre Intensive Residential/Day Treatment Client Information Package– to be completed by the client
- ☐ Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF) – to be completed by the client
- ☐ Florida Obsessive Compulsive Inventory (FOCI) – to be completed by the client
- ☐ Referring Physician's Consult Note

Eligibility Criteria

- ☐ Age is between 18-65 years
- ☐ Principal diagnosis is OCD (if there are comorbidities, OCD must be the disorder that causes the greatest amount of daily impairment)
- ☐ Symptoms must be judged as severe
- ☐ Patient's functioning is severely impaired

OCD symptoms must be treatment resistant. Specifically, the illness has not responded to:

- ☐ • 2 or more SSRIs **AND**
- ☐ • 1 or more trial of clomipramine or SNRI (Effexor, Pristiq) **AND**
- ☐ • 1 or more augmentation agent (atypical antipsychotics, memantine, or topiramate) * **AND**
- ☐ • 1 trial of evidence-based CBT*
- ☐ Willingness and motivation to challenge OCD symptoms
- ☐ Patient must have GP and ideally a therapist in their community willing to provide ongoing medication management and therapy

We are generally unable to provide care if the patient exhibits any of the following (patients with the following issues may not be eligible for an episode of care through our severe service):

- Current psychotic symptoms
- Current active suicidality
- Active substance dependence (within last 6 months)
- Current active trauma-related symptoms
- Current active anorexia nervosa

If your patient does not fit our criteria above but you feel they should be seen by the Thompson Centre, please outline the reason below:

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Thank You,
The Frederick W. Thompson Anxiety Disorders Team

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Date: ________________________

Requested treatment ☐ Residential ☐ Day Program*

Day Program: This is an option for patients whose functioning will allow them to reliably attend core programming Monday to Friday * between 9 a.m. to 5 p.m. while residing at home.

REFERRING PHYSICIAN INFORMATION

Referring Physician Name: ____________ MD Billing #: ____________

Address: ____________ Postal Code: ____________

Phone Number: ____________ Fax Number: ____________

Email: ____________

Does this patient currently have a psychiatrist? ____________

Name: ____________ Phone Number: ____________

PATIENT INFORMATION

Last Name: ____________ First Name: ____________

Gender: ❒ Male ❒Female ❒ Transgendered ❒ Non-binary ❒ Other ____________

Address: ____________ Postal Code: ____________

Date of Birth (dd/mm/yyyy): ____________ OHIP #: ____________ Version Code: ____________

Phone Number: ____________ Can a message be left? Yes / No With another person? Yes / No

Name: ____________ Relation: ____________ Phone Number: ____________

Please provide a brief history of the patient's OCD including current symptoms:

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What is the patient's current level of functioning? Can they work/attend school? How impairing is the OCD? Can they perform their activities of daily living (ADL's)?

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Please list any co-morbid psychiatric conditions that may interfere with treatment. Please note current state of these conditions:

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Is there any current/past substance abuse history, including any treatment for substance abuse?

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Does the patient have any history of acting violently or demonstrating aggressive behavior? Any legal issues?

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Does this patient have a history of impulsive or self-injurious urges? If so, what are these behaviors? What coping skills has he/she learned to try to manage the urges?

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Has this patient ever attempted suicide in the past? Please provide details (i.e., When did this occur, method of attempt?)

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Is there any current suicidal ideation? If so, please describe.

Please tell us about the patient's current support system and living situation. Is their living situation stable and can they return there after treatment?

How involved is the patient's family in their care? Does the family accommodate the patient's OCD (i.e., provide reassurance with respect to their obsessions and or compulsions; do they participate in rituals for the patient?)

Medical and Treatment History

Please provide information about the patient's medication history (if applicable), including any medical issues and what type of care is required to manage them.

How motivated do you feel your patient is to engage in an intensive and demanding treatment program at this time? Please describe.

What do you identify as barriers to this patient's ability to benefit from and participate in treatment (i.e., interpersonal style; level of insight into symptoms, ability to grasp skills and concepts; significant cognitive challenges; secondary gains)?