Sunnybrook
FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE

FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE

PHYSICIAN REFERRAL FORM: SEVERE OCD SERVICES

General Inquiries: (416) 480-4002 **Referral Status:** (416) 480-4426 **Fax:** (416) 480-5766
Email: thompsoncentreclinic@sunnybrook.ca **Website:** www.sunnybrook.ca/thompson

Please note: We do not provide urgent care services. Patients should be directed to their nearest Emergency Department.

Date (yyyy/mm/dd): _____

PATIENT INFORMATION

Last name:	First name:	
Chosen/preferred name:		
Pronouns:	Gender identity:	
Street address:		
City/town:	Province:	Postal code:
Date of birth (yyyy/mm/dd):	OHIN:	Version code:

Contact Information

Primary phone number:	Type:	◯ Home	◯ Mobile
Alt. phone number:	Type:	◯ Home	◯ Mobile
Can a message be left?	◯ Yes	◯ No	
With another person?	◯ Yes	◯ No	
If yes above, name of other person:		Relation:	
Email address:			
Email contact consent approved?	◯ Yes	◯ No	

REFERRING PROVIDER INFORMATION

Name:		Billing number:
Select one:	◉ Primary Care/Family Physician ◯ Other, please specify:	◯ Psychiatrist
Street address:		
City/town:	Province:	Postal code:
Phone number:	Fax number:	
Email:		

SPECIFY CLINICAL SERVICE

Refer to Eligibility Criteria on pg. 2 before selecting a service. Contact our office for availability of in-person and virtual options.

☐ **Psychiatric Consultation**
Referral will be reviewed and assigned to staff psychiatrist. Your patient will meet with the psychiatrist to discuss their current symptoms and review their history to make medication and treatment suggestions. The consultation is approximately 1.5-2 hours. After the consultation, the patient returns to the care of the referring provider. A comprehensive report with treatment recommendations will be sent back to the referring provider.

☐ **Outpatient Cognitive Behavioural Therapy (CBT) and/or Mindfulness-Based Cognitive Therapy (MBCT)**
Your patient will be contacted for a brief phone screen and scheduled for a psychological assessment (Structured Clinical Interview for the DSM-5). The assessment will determine appropriateness of CBT and/or MBCT for OCD group treatment. Treatment comprises of 12 two-hour weekly sessions in groups of up to nine, facilitated by a psychiatrist or clinical psychologist.

☐ **Intensive Live-In and Day Treatment Program (SUPPLEMENTAL FORMS REQUIRED)**
Your patient will be contacted for an intake interview. The clinical team will determine appropriateness of intensive OCD treatment and determine most suitable format (live-in, day treatment, virtual, hybrid) based on patient's needs. The treatment model integrates psychological and psychopharmacological interventions to provide a comprehensive approach to care which includes medication management, individual CBT and group treatment. The key feature is Exposure and Response/Ritual Prevention (ERP), the gold standard for treatment of OCD, which will occupy a significant portion of treatment time each day. While each patient is different, most individuals will be in the Intensive Program around 12 weeks.

The Thompson Centre is committed to serving communities with diverse backgrounds, traditions, beliefs and experiences. A part of this commitment is updating language such as "residential" or "inpatient" to **live-in**.

Thank you for supporting our efforts to ensure that the language we use is aligned with our goal of creating an equitable, inclusive and respectful environment for all communities we serve.

Sunnybrook
FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE

FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE
Severe OCD Services Referral

PATIENT IDENTIFICATION

ELIGIBILITY CRITERIA

Patient must meet eligibility criteria in all of the following categories in order to be eligible for Severe OCD Services at the Thompson Centre. Criteria vary depending on the clinical service requested. Please refer to the tables below:

	Psychiatric Consultation	**Outpatient CBT or MBCT**	**Intensive Live-In and Day Treatment Program**
☐ **Age**	18+	18-65	18-70
☐ **Diagnosis**	Principal diagnosis is OCD (if there are comorbidities, OCD must be the disorder that causes the greatest amount of daily impairment)		
☐ **Severity**	Symptoms must be judged as severe (see attached *Florida Obsessive Compulsive Inventory*)		
☐ **Functioning**	Patient's functioning is severely impaired		
☐ **Primary care**	Patient must have GP and ideally a therapist in their community willing to provide ongoing medication management and therapy		

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

	Psychiatric Consultation	**Outpatient CBT or MBCT**	**Intensive Live-In and Day Treatment Program**
☐ **SSRIs**	1 or more SSRIs		2 or more SSRIs
☐ **Additional trials**	1 or more trial of clomipramine **OR** SNRI (Effexor, Pristiq) **OR** 1 or more augmentation agent (atypical antipsychotics, memantine, or topiramate)		1 or more trial of clomipramine **OR** SNRI (*Effexor, Pristiq*) **AND** 1 or more augmentation agent (atypical antipsychotics, memantine, or topiramate**)**
☐ **CBT**	1 trial of evidence-based CBT **OR** inability to access CBT locally		

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

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

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

Version December 2022

Sunnybrook
FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE

FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE
Severe OCD Services Referral

PATIENT IDENTIFICATION

REASON FOR REFERRAL	
☐ Diagnostic clarification	☐ Treatment recommendations
Details of referral (including target symptoms and goals of treatment):	

PSYCHIATRIC DIAGNOSES
Please list all current and past psychiatric diagnoses:

CURRENT PSYCHIATRIC MEDICATION(S) ☐ Not applicable

Medication	**Reason**	**Dose**	**Duration** (weeks/months/ years)	**Response** (much improved/minimally improved/no change/minimally worse/much worse)	**Tolerability** (Side effects: none/mild/moderate/severe)
e.g., Cipralex	*OCD*	*20 mg*	*1 year*	*Minimally improved*	*Mild side effects*

Version December 2022

Sunnybrook
FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE

FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE
Severe OCD Services Referral

PATIENT IDENTIFICATION

PAST PSYCHIATRIC MEDICATION(S) ☐ Not applicable

Medication	Reason	Dose	Duration (weeks/months/years)	Response (much improved/minimally improved/no change/minimally worse/much worse)	Tolerability (Side effects: none/mild/moderate/severe)

PAST PSYCHIATRIC HOSPITALIZATIONS ☐ Not applicable

Date	Hospital	Reason

CURRENT AND PAST PSYCHOTHERAPY ☐ Not applicable

Type	Provider	Reason	Frequency	Start/End Dates	Response (much improved/minimally improved/no change/minimally worse/much worse)

Version December 2022

Sunnybrook
FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE

FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE
Severe OCD Services Referral

PATIENT IDENTIFICATION

CURRENT AND PAST MEDICAL HISTORY

Indicate if the patient has received a diagnosis of any of the following:

- ☐ Heart failure
- ☐ High cholesterol
- ☐ Liver disease
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Kidney disease
- ☐ Heart condition
- ☐ Asthma
- ☐ Stroke
- ☐ Seizures/epilepsy
- ☐ Intestinal problems
- ☐ High blood pressure/ hypertension
- ☐ Reflux disease
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Heart attack/by-pass surgery
- ☐ Cancer – if so, type and location: _____

Drug allergies: _____

Other allergies: _____

Other health conditions: _____

PAST MEDICAL HOSPITALIZATIONS

☐ Not applicable

Examples: head injuries, concussions, broken bones, surgical procedures

Date	Hospital	Reason

CURRENT NON-PSYCHIATRIC MEDICATION(S)

☐ Not applicable

List any medications the patient is taking for medical conditions.

Medication	Reason	Dose	Duration (weeks/months/years)	Response (much improved/minimally improved/no change/minimally worse/much worse)

Version December 2022

Sunnybrook
FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE

FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE
Severe OCD Services Referral

PATIENT IDENTIFICATION

THE FLORIDA OBSESSIVE COMPULSIVE INVENTORY: PART A

General Instructions:
The questions below are designed to help health professionals evaluate anxiety symptoms. Keep in mind, a high score on this questionnaire does not necessarily mean you have an anxiety disorder — only an evaluation by a health professional can make this determination. Answer these questions as accurately as you can.

PART A Instructions:
Please check YES or NO for the following questions, based on your experience in the past MONTH.

		YES	NO
Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:			
1	Concerns with contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS?	○	○
2	Overconcern with keeping objects (clothing, tools, etc.) in perfect order or arranged exactly?	○	○
3	Images of death or other horrible events?	○	○
4	Personally unacceptable religious or sexual thoughts?	○	○
Have you worried a lot about terrible things happening, such as:			
5	Fire, burglary or flooding of the house?	○	○
6	Accidentally hitting a pedestrian with your car or letting it roll down a hill?	○	○
7	Spreading an illness (giving someone AIDS)?	○	○
8	Losing something valuable?	○	○
9	Harm coming to a loved one because you weren't careful enough?	○	○
Have you worried about acting on an unwanted and senseless urge or impulse, such as:			
10	Physically harming a loved one, pushing a stranger in front of a bus, steering your car into oncoming traffic; inappropriate sexual contact; or poisoning dinner guests?	○	○
Have you felt driven to perform certain acts over and over again, such as:			
11	Excessive or ritualized washing, cleaning or grooming?	○	○
12	Checking light switches, water faucets, the stove, door locks or the emergency brake?	○	○
13	Counting, arranging; evening-up behaviors (making sure socks are at same height)?	○	○
14	Collecting useless objects or inspecting the garbage before it is thrown out?	○	○
15	Repeating routine actions (in/out of chair, going through doorways, relighting cigarettes) a certain number of times until it feels just right?	○	○
16	Needing to touch objects or people?	○	○
17	Unnecessary rereading or rewriting; opening envelopes before they are m	○	○
18	Examining your body for signs of illness?	○	○
19	Avoiding colors (“red” means blood), numbers (“13” is unlucky) or names (those that start with “D” signify death) that are associated with dreaded events or unpleasant thoughts?	○	○
20	Needing to “confess” or repeatedly asking for reassurance that you said or did something correctly?	○	○
If you answered YES to one or more of these questions, please continue with PART B.			

Sunnybrook
FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE

FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE
Severe OCD Services Referral

PATIENT IDENTIFICATION

THE FLORIDA OBSESSIVE COMPULSIVE INVENTORY: PART B

Part B Instructions:
The following questions refer to the repeated thoughts, images, urges or behaviors identified in Part A. Consider your experience during the past 30 days when selecting an answer.

Check the box most appropriate number from 0 to 4.

In the past month…

1.	On average, how much *time* is occupied by these thoughts or behaviours each day?	◉ 0 None	○ 1 Mild (less than 1 hour)	○ 2 Moderate (1 to 3 hours)	○ 3 Severe (3 to 8 hours)	○ 4 Extreme (more than 8 hours)
2.	How much *distress* do they cause you?	◉ 0 None	○ 1 Mild	○ 2 Moderate	○ 3 Severe	○ 4 Extreme (disabling)
3.	How hard is it for you to *control* them?	◉ 0 Complete control	○ 1 Much control	○ 2 Moderate control	○ 3 Little control	○ 4 No control
4.	How much do they cause you to *avoid* doing anything, going anyplace or being with anyone?	◉ 0 No avoidance	○ 1 Occasional avoidance	○ 2 Moderate Avoidance	○ 3 Frequent and extensive avoidance	○ 4 Extreme avoidance (housebound)
5.	How much do they *interfere* with school, work or your social or family life?	◉ 0 None	○ 1 Slight interference	○ 2 Definitely interferes with functioning	○ 3 Much interference	○ 4 Extreme interference (disabling)

For clinician use:
Sum on PART B (add items 1 to 5): _____
Keep in mind, a high score on this questionnaire does not necessarily mean you have an anxiety disorder—only an evaluation by a health professional can make this determination.

Version December 2022