CAN-BIND Canadian Biomarker Integration Network in Depression

PATIENT REFERRAL FORM

Study: Examining the effect of Music and Rhythmic Sensory Stimulation on Major Depressive Disorder

Principal Investigator:
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Principal Investigator, Canadian Biomarker Integration Network for Depression, University Health Network

Main Inclusion Criteria:

☐ Outpatients 18 to 60 years of age.
☐ Meet DSM-IV-TR criteria for MDE in MDD without psychotic features
☐ Episode duration ≥ 3 months.
☐ MADRS score ≥ 15 (mild to severe symptoms intensity).
☐ Fluency in English, sufficient to complete the interviews and self-report questionnaires.
☐ Satisfactory hearing bilaterally based on self-report.

Exclusion Criteria:

☐ Any Axis I diagnosis (other than MDD), and MDD with psychotic features, that is considered the primary diagnosis.
☐ Fibromyalgia diagnosis.
☐ Bipolar I or Bipolar-II diagnosis.
☐ Presence of a significant Axis II diagnosis (borderline, antisocial), judged as being primary diagnosis.
☐ High suicidal risk, defined by clinician judgment.
☐ Substance dependence/abuse in the past 6 months.
☐ Presence of significant neurological disorders, head trauma, or other unstable medical conditions.
☐ Acute and active inflammatory conditions, rheumatoid arthritis, osteoarthritis, autoimmune disease.
☐ History of epilepsy, seizures.
☐ Hemorrhaging or active bleeding.
☐ Hearing impairment.
☐ Thrombosis or heart diseases, including hypotension, arrhythmia, pacemaker, angina pectoris.
☐ Pregnant or breastfeeding.
☐ Recovering from recent accident with prolapsed vertebral disc, back or neck injury.
☐ Started psychological treatment within the past 3 months with the intent of continuing treatment.
☐ Patients who have changed medication or adjusted medication dosage within 4 weeks.

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PATIENT'S INFORMATION:

Name: _____

Tel: H (_____) _____ W (_____) _____

Email: _____

REFERRING PHYSICIAN: (*Patient must be referred by a physician*)

☐ Family Physician ☐ Psychiatrist

Name: _____ Billing Number: _____

Address: _____

Tel: (_____) _____ Fax: (_____) _____

Email: _____

_____
Date of Referral

_____
Signature

Referrals to be sent to:
Fax # 416-603-5368 (Attn: Dr. Sidney Kennedy)