Family Wellness Center of Norman
2760 Washington Drive Suite 110
Norman, OK 73069
(405) 360-2827 Fax (405) 283-1124

TMS Consent Form

Transcranial magnetic stimulation (TMS) is applied by resting a helmet with a coil on the patient's head; an electrical current flows through the coil generating a magnetic field that penetrates through the skull and induces a second electrical flow of current in the bilateral prefrontal cortex of the brain. When finding the patient's motor threshold (MT) as the current flows through the coil, the patient will experience involuntary activation of different muscle groups (typically in the hand, fingers, and thumb) depending on the positioning of the coil over the motor cortex. Repetitive TMS is an innovative treatment currently only FDA approved for major depression that has failed to respond to medication. A course of treatment for depression typically ranges from 20-36 treatments, with treatments occurring 5 days per week initially, and then decreased to twice a week. Additionally, you may need maintenance sessions or retreatment for a recurrence. Before starting TMS, you should discuss with the doctor alternative treatment options, including different medications, combinations of medications, therapy, and Electro-Convulsive-Therapy (ECT) and understand the relative odds of success and side effects. Please understand the patient can choose to get TMS and/or treatment at another center, which Family Wellness Center of Norman does not have ownership in.
TMS is prescribed and directly supervised by psychiatrist, nurse practitioners, and staff who are trained in TMS as well as numerous other treatment modalities. TMS is administered by trained TMS technicians who are familiar with different TMS protocols but may only administer exactly what is prescribed. They are not clinicians and may not make treatment recommendations, they administer TMS all day every day and are trained to handle an emergency. Physician and nurse practitioner supervision takes place in many ways.

- Through an initial diagnosis, treatment planning with a decision to utilize a specific TMS protocol.
- Treatment progress is monitored through patient rating scales and follow up appointments.
- If necessary, the TMS operator can call the physician or nurse practitioner to answer a question and have the physician or nurse practitioner observe the treatment in person or via video.
- If there is some uncertainty about whether to continue TMS or change the protocol, this should be discussed with the physician or nurse practitioner in an appointment and not the operator. Rating scales may be annoying, but they are required for data collection for publication and insurance coverage determinations. If you feel a better scale may be more applicable to you, let us know. We have different options for scales.

Risks and Discomforts

TMS has been used worldwide since 1985; a series of adverse effects can occur from TMS.
I understand the following adverse effects are possible:

- Up to 10% of patients undergoing TMS experience headaches, face pain, jaw pain, tooth pain or neck pain. I will be offered (or I can take in advance) ibuprofen, acetaminophen, or aspirin, which in most cases relieves the pain. Almost all patients find TMS to be tolerable.
- TMS produces a loud clicking noise during stimulation, which can result in tinnitus or hearing loss especially if ear protection is not used. To prevent risk of hearing disturbances, earplugs will be given to wear. The risk of hearing loss with hearing protection is not known but is most likely less than 0.01% or 1 in 10,000 patients.
- TMS can induce a convulsion even in the absence of brain lesions, epilepsy, or other risk factors for seizures. The overall risk for seizures during TMS is not known but it is less frequent than 0.5% or 5 in 1,000 patients. TMS does not cause epilepsy. In patients with known epilepsy, the risk is 1%.
- TMS could potentially cause inadvertent teeth clenching, biting of the tongue and chipping teeth. The overall risk for this is not known.
- TMS could theoretically induce transient changes in cognition or movement, although safety studies have not found such side effects to date.
- I am aware there may be some unexpected complications.
- I am aware that the risks of exposure to a magnetic field during pregnancy are not fully understood.

First name: _____ Last name: _____

DOB: _____/_____/_____ Signature: _____ Date: _____/_____/_____

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There is only one absolute contraindication for repetitive TMS, the presence of a ferromagnetic substance in the head. Ferromagnetic means a substance that is highly susceptible to magnetization. We do not know about long-term consequences of TMS, since it was only FDA approved for depression in 2008. It is strongly advised not to interrupt your treatment during the acute phase.

Insurance Eligibility and Payments

Most private insurers, such as Blue Cross Blue Shield of Oklahoma and Tricare, cover treatments of TMS for Major Depressive Disorder. When treatments are covered by insurance, patients will typically incur the co-pay per treatment session, and the amount of treatments are dictated by the insurance plans. We will run your insurance through an eligibility verification check before treatments to determine if insurance will cover treatments. Our office also has payment plans available to break up the cost over a short period of time.

Because depression, alcohol, drug, and tobacco use can have a negative effect on your health, we ask EVERYONE to answer the following questions to optimize benefits of the appointment. We also ask that if anything changes during your treatments, to please let us know before treatments.

1. Do you have metal or implants in or around your head? [ ] Yes [ ] No
   If yes, what? _____
   Due to the deep magnetic stimulation of TMS, patients with metal in the head area such as screws, metal plates, aneurysm coils, cochlear implants, ocular implants, stents, pacemakers, defibrillators, and vagus nerve stimulators may not be eligible for treatment.
   Any metal in face, ears, or surrounding the head area, including facial piercings, glasses, and hair accessories, will be asked to be removed during the treatment. Dental fillings, braces, or retainers are fine during treatments.
2. Do you have epilepsy, a family history of epilepsy, or have you had a seizure before? [ ] Yes [ ] No
   If yes, are you taking medication for seizures? [ ] Yes [ ] No If yes, regularly? [ ] Yes [ ] No
   Seizure Doctor's Name: _____ Last visit date: ____/____/_____
   Medication: _____ Date of last seizure: ____/____/_____
   Patients with seizures have an increased risk of seizures with TMS treatments. It is important to remain taking any seizure medications consistently and let your provider know of any changes.
3. Have you had any severe trauma, concussion, or injury to the head? [ ] Yes [ ] No
   If yes, when? ____/____/_____ If yes, what? ____/____/_____
4. Do you have a pre-existing condition of retinal detachment? [ ] Yes [ ] No
   When was your last eye exam? ____/____/_____
5. Are you pregnant or nursing? [ ] Yes [ ] No
6. How much coffee, energy drinks or caffeine do you typically drink per day? _____
7. Do you drink? [ ] Yes [ ] No If yes, what? _____
   How much alcohol do you typically drink per day? _____
8. Do you smoke? [ ] Yes [ ] No If yes, what? _____
   How much do you typically smoke per day? _____
9. Do you use drugs? [ ] Yes [ ] No If yes, what? _____
   How much do you typically use per day? _____
10. Do you see a therapist? [ ] Yes [ ] No If yes, who? _____
    If yes, regularly? [ ] Yes [ ] No Last visit date: ____/____/_____
11. Do you see a physician regularly? [ ] Yes [ ] No If yes, who? _____
    If yes, regularly? [ ] Yes [ ] No Last visit date: ____/____/_____
12. Are there any other medications, other than prescribed in our office that you take? [ ] Yes [ ] No
    _____
    _____
    _____

First name: _____ Last name: _____

DOB: _____/_____/_____ Signature: _____ Date: _____/_____/_____

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PHQ-9 Questionnaire

Over the last **2 weeks**, how often have you been bothered by any of the following problems? **(Use an "X" to indicate your answer)**	**Not at all** (0)	**Several days** (1)	**More than ½ the days** (2)	**Nearly every day** (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure, or have let yourself or family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or thoughts of hurting yourself in some way				
If you checked off any problems, how difficult have these problems made it for you to do everyday tasks? ( ) Not difficult at all ( ) Somewhat difficult ( ) Very difficult ( ) Extremely difficult				
***For Healthcare professionals only* Client's Total PHQ-9 Score: _____/27**				

First name: _____ Last name: _____

DOB: _____/_____/_____ Signature: _____ Date: _____/_____/_____