



Front Street Clinic

Guidelines for Beginning TMS

1. A standard course of TMS is administered in 35 treatment sessions over an eight-week course. The First five weeks will start on a Monday with treatments each weekday. During the last three weeks the frequency will taper off.
2. It is essential that you not start TMS unless you can commit to this eight-week schedule and can schedule daily treatments at times worked out with the team missing more than four days in a row (including weekends) during the initial five weeks will significantly reduce the chance of the treatment working. If that happens it is recommended that the treatment schedule should start again from the very beginning. This is very costly, and insurance companies will not pay for it.
3. A standard treatment session is less than thirty minutes long, but the first session will last up to two hours. During the first session, informed consent forms will be reviewed and signed, the individualized location and strength for your magnetic pulses will be calibrated, and you will receive your first course of repetitive pulses.
4. Until your scalp gets used to the pulses after several sessions, it helps to take ibuprofen/Motrin 400–600mg or naproxen/Naprosyn 375–500mg (take higher doses with an antacid) or acetaminophen (Tylenol) 1–2 hours before the appointment. If you happen to have a mouth guard, we recommend bringing that as well, in case your jaw quivers with the pulses.
5. Before each treatment session you should eat something, and you should use the bathroom. You should also remove any jewelry or other metal objects around your head or neck. We will check with you each time to make sure these things were done.
6. We will also check each time about any changes in your medicines or your use of caffeine or alcohol, or major changes in your sleep pattern. These can alter the strength of the pulses required to adequately and safely treat you.
7. You may have one person (at least 18 years old) accompany you during TMS for support, but it is essential especially during the first session that they not distract or interfere with the procedure.

TRANSCRANIAL MAGNETIC STIMULATION QUESTIONNAIRE

Please take a few minutes to answer these questions. This will save you and me some time and help us get organized. Most of the questions can be answered briefly but use the back if you need to.

Name: _____ DOB: _____ Date: _____

Sex: _____ Marital Status: _____ Occupation: _____

Depression History

At what age did you first have a serious episode of depression?

Since then, has it been constant, or does it come and go?

Does the time of year make a huge difference in your level of depression? Yes ____ No ____

When you are at your most depressed, does it affect your:

Sleep? Yes ____ No ____

Appetite? Yes ____ No ____

Ability to enjoy things? Yes ____ No ____

Memory or concentration? Yes ____ No ____

Relationships with loved ones? Yes ____ No ____

Ability to work at a job or around your home? Yes ____ No ____

History of Your Current Depressive Episode

How long has your current episode of depression been going on?

Please rank your current depression with an X on the scale below:

No Depression : _____ : Intolerable

Right now, if you use your imagination and look into the future, is it easy or is it hard to imagine a time when you will enjoy your life again?

Easy ____ Hard ____

Are you having thoughts of suicide or of harming yourself or others?

Yes ____ No ____

History of Possible Mania, Hypomania, or Psychotic Symptoms

Have you ever had any periods of time when you were opposite of being depressed, when not only did you feel fine, but you felt far too good? During such an episode, you might have felt you didn't need sleep, you didn't need food, your mind was racing, people told you to slow down or quiet down when you were talking, you had boundless energy and started (but often did not complete) lots of projects, you spent much more money than normal, were much more outgoing, had an increased sex drive, had an inflated sense of your abilities or your future

Yes ____ No ____

How old were you when you first had such an episode?

How old were you the last time you had such an episode?

What is the longest that such an episode has ever lasted?

Have you ever had (when depressed or not) unusual experience, such as hearing or seeing things that are not there, or developing paranoia or strong beliefs that were unusual for you?

Yes ____ No ____

Antidepressant Medication History

Please list any psychiatric medicines you are currently taking:

Please list any other antidepressant medications you have been tried on earlier during this depressive episode:

Please circle any of the following medications that you have been on in the past depressive episodes:

SSRIs:	Prozac (fluoxetine) Paxil (paroxetine) Zoloft (sertraline)	Celexa (citalopram) Lexapro (escitalopram) Luvox (fluvoxamine)
SNRIs:	Effexor (venlafaxine) Cymbalta (duloxetine)	Pristiq (desvenlafaxine)
Others:	Wellbutrin (bupropion) Remeron (mirtazapine)	Serzone (nefazodone) Viibryd (vilazodone)
MAOIs:	Nardil (phenelzine) Parnate (tranylcypromine)	Eldepry/Emsam Patch (selegiline)
TCAs:	Elavil (amitriptyline) Pamelor (nortriptyline) Tofranil (imipramine) Sinequan/Adapin (doxepin)	Anafranil (clomipramine) Vivactyl (protriptyline) Ludiomil (maprotiline)
Mood Stabilizers:	Lithium Depacote (valproic acid) Tegretol (carbamazepine)	Lamictal (lamotrigine) Trileptal (oxcarbazepine)
Atypical Neuroleptics:	Abilify (aripiprazole) Risperdol (risperidone) Saphris (asenapine) Fanapt (iloperidone) Latuda (lurasidone)	Seroquel (quetiapine) Zyprexa (olanzapine) Geodon (ziprasidone) Invega (paliperidone)

Have you ever had Electroconvulsive Therapy (ECT)? Yes _____ No _____

Medical History

Please list any medications to which you are allergic:

Please list any medical illnesses you have for which are under a doctor's care, or ought to be under a doctor's care:

Please list any non-psychiatric medications (and doses) you are currently taking:

Please list any over-the-counter medicines or herbal supplements you are taking on a regular basis:

How much caffeine, if any, do you currently drink each day?

Please list any street drugs (marijuana, cocaine, meth, heroin, etc.) that you currently use.

Neurological History

Have you ever had any serious injuries to your head or brain? Yes ____ No ____

Have you had surgery (except dental) on any part of your head or neck? Yes ____ No ____

Have you ever been turned down for an MRI scan of your head or neck? Yes ____ No ____

Have you ever had a seizure, convulsion, epilepsy? Yes ____ No ____

Have you ever been diagnosed with any brain diseases, such as Multiple Sclerosis, Parkinson's Disease, meningitis, strokes, tumors, cancer, etc.?
Yes ____ No ____

Any additional information?



Front Street Clinic
Patient Consent for a Medical Procedure
NeuroStar TMS Therapy

This is a patient consent for a medical procedure called NeuroStar TMS Therapy. This consent form outlines the treatment that your doctor has prescribed for you. The risks of this treatment, the potential benefits of this treatment to you, and any alternative treatments that are available for you if you decide not to be treated with NeuroStar TMS therapy.

The information contained in this consent form is also described in the Depression Patient's Manual for Transcranial Magnetic Stimulation with the NeuroStar TMS Therapy® System which is available from your doctor. Not all information in the manual is stated here, so you should read the patient manual and discuss any questions that you have with your doctor. Once you have reviewed the manual and this consent form, be sure to ask your doctor any questions that you may have about NeuroStar TMS Therapy.

_____, has explained the following information to me:

- A. TMS stands for "Transcranial Magnetic Stimulation". NeuroStar TMS Therapy is a medical procedure. A TMS session is conducted using a device called the NeuroStar TMS Therapy System, which provides electrical energy to a "treatment coil" or magnet that delivers pulsed magnetic fields. These magnetic fields are the same type and strength as those used in magnetic resonance imaging (MRI) machines.
- B. NeuroStar TMS Therapy is a safe and effective treatment for patients with depression who have not benefitted from antidepressant medications.
- C. Specifically, NeuroStar TMS Therapy has shown to relieve depression symptoms in adult patients who have been treated with one antidepressant medication given at high enough dose and for long enough period of time but did not get better.
- D. The safety and efficacy of NeuroStar TMS Therapy has not been established in patients taking two or more antidepressant medications at high enough dose and for a long enough period of time or who did not take any antidepressants during this current period of depression.
- E. During a TMS treatment session, the doctor or a member of their staff will place the magnetic coil gently against my scalp on the left front region of my head. The magnetic fields that are produced by the magnetic coil are pointed at a region of my brain that scientists think may be responsible for causing depression.
- F. To administer the treatment, the doctor or a member of their staff will first position my head in the head support system. Next, the magnetic coil will be placed on the left side of my head, and I will hear a clicking sound and feel a tapping sensation on my scalp. The doctor will adjust the NeuroStar TMS Therapy system so that the device will give just enough energy to send the electromagnetic pulses into the brain so that my right-hand twitches. The amount of energy required to make my head twitch is called the "motor threshold". Everyone has a different motor threshold and the treatments are given at an energy level that is just above my individual motor threshold. How often my motor threshold will be re-evaluated will be determined by my doctor.
- G. Once the motor threshold is determined, the magnetic coil will be moved, and I will receive the treatment as a series of 'pulses' that lasts about 4 seconds, with a 'rest' period of about 26 seconds between each. Series. Treatment is to the left front side of my head and will take about 40 minutes. I understand that this treatment does not involve any anesthesia or sedation and that I will remain awake and alert during the treatment. I will likely receive these treatments 5 times a week for 4 to 6 weeks (20 to 30 treatments). I will be evaluated by the provider _____ times during this treatment course. The treatment is designed to relieve my current symptoms of depression.
- H. During the treatment, I may experience tapping or painful sensations at the treatment site while the magnetic coil is turned on. These types of sensations were reported by about one third of the patients who participated in the research studies. I understand that I should inform the doctor or his/her staff if this occurs. The doctor may

then adjust the dose or make changes to where the coil is placed in order to help make the procedure more comfortable for me. I also understand that the headaches were reported in half of the patients who participated in the clinical trial for the NeuroStar device.

I. I understand both discomfort and headaches got better over time in the research studies and that I may take common over-the-counter pain medications such as acetaminophen if a headache occurs.

J. The follow risks are also involved with this treatment:

The NeuroStar TMS Therapy System should not be used by anyone who has magnetic-sensitive metal in their head or within 12 inches of the NeuroStar magnetic coil that cannot be removed. Failure to follow this restriction could result in serious injury or death. Object that may have this kind of metals includes:

- Aneurysm clips or coils
- Stents
- Implanted Stimulators
- Electrodes to monitor your brain activity
- Ferromagnetic implants in your ears or eyes
- Bullet fragments
- Other metal devices or objects implanted in the head
- Facial tattoos with metal ink or Permanent makeup.

K. The NeuroStar TMS System should be used with caution in patients who have pacemakers or implanted cardioverter defibrillators (ICDs) or are using wearable cardioverter defibrillators (WCD). Failure to follow this restriction could result in serious injury or death.

L. NeuroStar TMS Therapy is not effective for all patients with depression. Any signs of symptoms of worsening depression should be reported immediately to your doctor. You may want to ask a family member or caregiver to monitor your symptoms to help you spot any signs of worsening depression.

M. Seizures (sometimes called convulsions or fits) have been reported with the use of the TMS devices. However, no seizures were observed with the use of the NeuroStar TMS Therapy system in over 10,000 treatment sessions in trials conducted prior to the FDA clearance of NeuroStar TMS Therapy. Since the introduction of the NeuroStar TMS Therapy into clinical practice, seizures have been rarely reported. The estimated risk of seizure under ordinary clinic use is approximately 1 in 30,000 treatments or 1 in 1000 patients.

N. Because the NeuroStar TMS Therapy system produces a loud click with each magnetic pulse I understand that I must wear earplugs or similar hearing protection devices with a rating of 30dB or higher of noise reduction during treatment.

O. I understand that most patients who benefit from NeuroStar TMS Therapy experience results by fourth week of treatment. Some patients may experience results in less time while others may take longer.

P. I understand that I may discontinue treatment at any time.

I have read the information contained in the Medical Procedure consent form about the NeuroStar TMS Therapy and its potential risks. I have discussed it with my provider _____ who has answered all my questions. I understand there are other treatment options for my depression available to me and this has also been discussed with me.

I therefore permit _____ and his/her staff to administer this treatment on me.

Client Signature

Witness Signature

Date

FINANCIAL & INSURANCE POLICY FRONT STREET CLINIC

Client Name:

DOB:

INSURANCE APPROVAL: It is patients' responsibility to clarify his/her insurance eligibility and coverage details such as deductible, co-payment, and limitations. Our experienced staff will assist you as a courtesy only, free of charge. FSC does not get involved in insurance disputes but will provide clinical information required to facilitate the process.

DEDUCTIBLE AND CO-PAYMENT: Deductibles and co-payments are due before not adjustable by the law and payable prior to procedure.

INSURANCE AUTHORIZATION: Our physician and staff will do their best to pre-qualify for the coverage initially upon your request but have the right not to assist in any appeal process. Authorization of treatment is not a guarantee of payment. All unpaid balance is due upon request.

If you wish to proceed with treatment it is considered an elective service of your own choice.

TREATMENT OUTCOME: Is not satisfaction guaranteed. You have a chance to discuss the relevant research outcomes, benefits, and risk related to the treatment with your physician.

REFUND POLICY: Refunds will be considered in the case of a major documentable crisis: medical, legal, or familial. Otherwise no refund will be made for the unused service.

BOOST TREATMENT: Financial information is available upon your request. Please See our TMS coordinator.

Any unforeseen problem and issue please contact our TMS coordinator by calling (360) 697-1141 or email info@frontstreetclinic.com

I read, understand, and agree to comply with the above terms.

Client Signature

Date

Witness Name & Signature

Date

PHQ-9 & GAD-7

Name: _____

Date: _____

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or over eating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	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	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ9 – Total Score

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

If you check off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ at all
 ☐ Somewhat difficult
 ☐ Very difficult
 ☐ Extremely difficult

GAD7 – Total Score

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