MUSC Health
INSTITUTE OF PSYCHIATRY

Patient Name: _____

MRN: _____

Consent for TMS

Name of Attending Physician: _____

Name of Patient: _____

My doctor has recommended that I receive treatment with Transcranial Magnetic Stimulation (TMS). The nature of this treatment, including the risks and benefits that I may experience, has been fully described to me by _____, and I give my consent to be treated with TMS.

I will receive TMS to treat my psychiatric condition. I understand that there may be other alternative treatments for my condition which may include medications and psychotherapy. Whether TMS or an alternative treatment is most appropriate for me depends on my prior experience with these treatments, the nature of my psychiatric condition, and other considerations. Why TMS has been recommended for my specific case has been explained to me.

To administer the TMS 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 or right side of my head, and I will hear a clicking sound and feel a tapping sensation on my scalp. The doctor will then adjust the TMS system so that the device will give just enough energy to send electromagnetic pulses into my brain, so that my right or left hand twitches. The amount of energy required to make my hand 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.

Once motor threshold is determined, the magnetic coil will be moved, and I will receive the treatment as a series of "pulses" that last up to 4 seconds, with a "rest" period of about 1-26 seconds between each series. Treatment will take about 40 minutes but sometimes longer depending on your treatment parameters. I understand that this treatment does not involve any anesthesia or sedation and that I will remain awake and alert during the treatment. The number of treatments that I receive cannot be predicted ahead of time. The number of treatments will depend on my psychiatric condition, how quickly I respond to the treatment, and the medical judgment of my psychiatrist. 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 doctor at least weekly during this treatment course. The treatment is designed to relieve my current symptoms of depression.

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 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 headaches were reported in half of the patients who participated in clinical trial for TMS. I understand that 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.

RISK:

TMS should not be used by anyone who has magnetic-sensitive metal in their head or within 12 inches of the TMS coil that cannot be removed. Failure to follow this restriction could result in serious injury or death.

Objects that may have this kind of metal include:

- 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.

TMS is not effective for all patients with depression. Any signs or 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.

Seizures (sometimes called convulsions or fits) have been reported with the use of other types of TMS devices. I will let my doctor know if I have a seizure disorder or had a seizure in the past.

Because the TMS 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.

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

I understand that I should feel free to ask questions about TMS at this time or at any time during the TMS course or thereafter by calling 792-9888 (local) or 1-800-424-6872 (out-of-area) and requesting to speak with the doctor or any other member of the TMS team. I also understand that my decision to agree to TMS is being made on a voluntary basis, and that I may withdraw my consent and have the treatment stopped at any time.

The nature, proposed and possible consequences, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me. No guarantees or assurances have been made or given by anyone as to the results that may be obtained.

I, THE UNDERSIGNED, HAVE HAD THIS FORM EXPLAINED TO ME AND FULLY UNDERSTAND THE CONTENTS OF THIS AUTHORIZATION.

_____
Signature of Patient

Date _____

When patient is incompetent to affix signature:
Signature of person authorized to consent for patient _____

Address _____

_____

Authority to consent

_____

_____
Signature of Witness

Address _____

_____

Person obtaining consent: _____ Date: _____ Time: _____