Neuralia TMS

Transcranial Magnetic Stimulation Consent

Individualised Transcranial Magnetic Stimulation (TMS) is a non-invasive therapy using electromagnetic stimulation of the brain. The magnetic field produced by the procedure induces trace amounts of electrical current in the brain. It is used after diagnosis for treatment and has shown great promise in the treatment of certain conditions or disorders that are not responsive to conventional treatments.

The procedure is administered by placing a special coil over the head while the patient remains seated in a chair. A powerful, painless, magnetic field is pulsed into the brain based on a specific treatment protocol. Each session takes approximately 19 minutes. Patients are thoroughly screened and evaluated before the treatment and are monitored during TMS treatment session by a trained and TMS technician or other certified clinician or practitioner to minimize any risk from the procedure, to monitor the patient's response to treatment, and to monitor proper for continued treatment coil contact.

There is no guarantee that patients will respond positively to this therapy and as with all therapies, there is a chance of injury. However, transcranial magnetic stimulation is Therapeutic Goods Agency (TGA)-approved for specific conditions, such as major depressive disorder in adult patients, and other conditions depending on the TMS system being used for treatment. The results of research and clinical trials have shown improvement and positive results in patients suffering from various neuropsychiatric disorders including anxiety, attention deficit disorder, autistic spectrum disorder, mild and moderate traumatic brain injury, substance abuse, and other psychiatric and neurological conditions.

In certain circumstances seizures have been shown to occur. This average risk is believed to be 1 in 30,000 treatments.

About ten percent (10%) of patients undergoing this procedure will experience headaches and/or discomfort at the treatment site that may last several hours following the treatment. Some patients experience exacerbation or recurrence of previous symptoms during the early phase of treatment. Side effects generally subside after the first few treatment sessions.

Infection control measures at the Pioneer Health TMS service

Pioneer Health makes every endeavor to make your TMS sessions as safe as possible in order to minimize your risk of infection with respiratory viruses such as COVID. To this end our team will wear masks during TMS sessions and we also have a special ventilation system in the TMS room to safeguard our patients. We furthermore suggest that patients wear a mask to TMS sessions to give them additional protection from infections such as COVID. Of course should patients develop cold and flu symptoms we ask you to phone our TMS team at your earliest convenience

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PATIENT CONSENT

I, _____________________________________ have been informed of the effects, anticipated length of time of treatment, frequency and duration of treatment, side effects, benefits and risks of the treatment listed above and give my consent voluntarily to participate in with TMS treatment as per the TMS information sheet. I acknowledge having read the TMS information sheets and have been provided with the opportunity to discuss this material with the Psychiatrist and TMS operator.

I consent to receiving a up to 35 TMS treatment sessions as part of my TMS treatment course. I am aware that further or maintenance TMS sessions may be required. If this is the case a new prescription and consent form will be required.

I am aware of the initial treatment protocol, and that its parameters may change over the course of the treatment.

If receiving Medicare rebated TMS: *I declare that I am over 18 years old, have been diagnosed with a Major Depressive Episode, have not previously received TMS, have failed to receive satisfactory improvement for Major depressive episode despite the adequate trial of at least 2 different classes of antidepressant medication for at least 3 weeks.*

____
Doctor

____
Patient Name

____
Signature of Witness

____
Signature

____
Title of Witness

____
Date

Emergency Contact Name:____

Emergency Contact Phone:_________________________

Please note: it will be assumed that your emergency contact for TMS purposes will be aware that you are undergoing TMS treatment.

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DOCTOR'S DECLARATION:
I declare that the patient has been provided with the TMS information sheet and has been given a comprehensive explanation about TMS.

I declare that the patient has had adequate time to consider all factors related to their TMS treatment and has had adequate opportunity to discuss this with myself. This includes providing sufficient time for the patient to question myself and receive answers.

I declare that the patient is aware of the risks/benefits of TMS and alternative treatment options.

I declare that the patient can weigh up these options and adequately communicate his or her decisions regarding TMS in a manner that is voluntary, consistent and without coercion.

I declare that the patient demonstrates full capacity to make decisions regarding their participation in TMS treatment.

____
Doctor

____
Signature of Witness

____
Title of Witness

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