Srisai Gowda MD FAPA
Board Certified in General Psychiatry and Psychosomatic Medicine

Trans Cranial Magnetic Stimulation (TMS)

2106 New Road #D-8, Linwood, NJ 08221
ShoreClinicalTMS.com | 609-927-1030 | Fax: 609-927-9985

Your insurance company requires you to complete the form below in its entirety in order to get your TMS treatment approved.

Current Medications

Medication	Dosage	Instructions	Medication Start Date

Notes:

_____

_____

_____

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Medication	Dosage	Start Date	End Date	Results
SSRI				
Citalopram (Celexa)				
Escitalopram (Lexapro)				
Fluoxetine (Prozac)				
Fluvoxamine (Luvox)				
Paroxetine (Paxil)				
Sertraline (Zoloft)				
Vilazodone (Viibryd)				
Vortioxetine (Brintellix)				
SNRI				
Desvenlafaxine (Pristiq, Khedezla)				
Duloxetine (Cymbalta)				
Levomilnacipran (Fetzima)				
Venlafaxine (Effexor)				
TCAs				
Amitriptyline (Elavil)				
Amoxapine (Asendin)				
Clomipramine (Anafranil)				
Desipramine (Norpramin)				
Doxepin (Prudoxin, Silenor, Zonalon)				
Imipramine (Tofranil)				
Nortriptyline (Pamelor)				

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MAOIs				
Phenelzine (Nardil)				
Selegiline (Emsam)				
Tranylcypromine (Parnate)				
Atypical Antipsychotics				
Aripiprazole (Abilify)				
Brexpiprazole (Rexulti)				
Cariprazine (Vraylar)				
Clozapine (Clozaril)				
Lurasidone (Latuda)				
Olanzapine (Zyprexa)				
Quetiapine (Seroquel)				
Risperidone (Risperdal)				
Ziprasidone (Geodon)				
Other				
Adderall				
Bupropion (Wellbutrin)				
Buspirone (Buspar)				
Lithium				
Mirtazapine (Remeron)				
Nefazodone (Serzone)				
Trazodone (Desyrel, Oleptro)				

Shore Clinical TMS & Wellness Center
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Therapy/ Psychotherapy History

Therapist	Type of Therapy	Start Date	End Date	Frequency	Outcome
	CBT (cognitive behavior) ☐ IPT (Interpersonal) ☐ DBT (Dialectical) ☐ Psychodynamic ☐ Supportive ☐ Family ☐			Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:____	
	CBT (cognitive behavior) ☐ IPT (Interpersonal) ☐ DBT (Dialectical) ☐ Psychodynamic ☐ Supportive ☐ Family ☐			Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:____	
	CBT (cognitive behavior) ☐ IPT (Interpersonal) ☐ DBT (Dialectical) ☐ Psychodynamic ☐ Supportive ☐ Family ☐			Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:____	

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TMS Patient Screening

Patient Name: _____ DOB: _____

This section is to filled out by the patient/ patient representative. Please indicate if you have any of the following.

Brain Aneurysm clips or coils	☐ Yes	☐ No	Wearable cardioverter defibrillator	☐ Yes	☐ No
Cardiac pacemaker or wires	☐ Yes	☐ No	Implanted insulin pump	☐ Yes	☐ No
Internal cardioverter defibrillator (ICD)	☐ Yes	☐ No	Programmable shunt or valve	☐ Yes	☐ No
Carotid or cerebral stents	☐ Yes	☐ No	Hearing Aid	☐ Yes	☐ No
Metallic devices implanted in your head	☐ Yes	☐ No	Cervical fixation devices	☐ Yes	☐ No
Dental Implants	☐ Yes	☐ No	Surgical clips, staples, or sutures	☐ Yes	☐ No
Cochlear Implant/ Ear Implant	☐ Yes	☐ No	Wearable monitor (e.g., heart monitor)	☐ Yes	☐ No
CSF (cerebrospinal fluid) shunt	☐ Yes	☐ No	Bone Growth Stimulator	☐ Yes	☐ No
Eye Implants	☐ Yes	☐ No	Wearable Infusion Pump	☐ Yes	☐ No
Cardiac stents, filters, or metallic valves	☐ Yes	☐ No	Radioactive Seeds	☐ Yes	☐ No
Tattoo	☐ Yes	☐ No	Medication patch/ Nicotine Path	☐ Yes	☐ No
Vagus nerve stimulator (VNS)	☐ Yes	☐ No	Other implanted metal or device	☐ Yes	☐ No
Blood vessel coil	☐ Yes	☐ No	If yes, please specify: _____		

Age: _____ Weight (lbs.): _____ Height: _____ Last Menstrual Cycle: _____

Are you pregnant? ☐ Yes ☐ No

Have you ever been a machinist, welder, or metal worker? ☐ Yes ☐ No

Have you ever had a facial injury from metal and/ or metal removed from your eyes? ☐ Yes ☐ No

Have you ever had complications from an MRI? ☐ Yes ☐ No

Have you ever had a seizure? ☐ Yes ☐ No

Signature of person completing form: _____ Date: _____

Signature of physician/health care provider: _____ Date: _____

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Patient Consent for TMS Treatment

This is a patient consent for a medical procedure called TMS Treatment. This consent form outlines the treatment that your doctor has prescribed for you or you have chosen to pursue, 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 TMS Treatment.

Dr. Srisai Gowda, M.D., F.A.P.A, has explained the following information to me:

A) TMS stands for "Transcranial Magnetic Stimulation". TMS Treatment is a medical procedure. A TMS treatment session is conducted using a device called the TMS Treatment System, which provides electrical energy to a "treatment coil" or magnet that delivers post magnetic fields. These magnetic fields are the same type and strength as these used in magnetic resonance imaging (MRI) machines.

B) TMS Treatment is a safe and effective treatment for patients with depression who have not benefitted from antidepressant medications.

C) Specifically, TMS Treatment has been shown to relieve depression symptoms in adult patients who have been treated with one antidepressant medication given at a high enough dose and for a long enough period of time but did not get better.

D) 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 the brain (DLPFC) that scientists think may be responsible for causing depression.

E) 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 then adjust the TMS Treatment system so that the device will give just enough energy to send electromagnetic pulses into the brain so that my right 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 reevaluated will be determined by your doctor.

F) Once motor threshold is determined, the magnetic coil will be moved, and I will receive the treatment as a series of "pulses", with a "rest" period of about 20 seconds between each series. Treatment is to the left front side of my head and will take about 20-45 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 initially receive these treatments 5 times a week for 4 weeks (20 treatments) and I understand that additional treatments may be required in order to achieve maximum response. The treatment is designed to relieve my current symptoms of depression.

G) During the treatments, 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 to me. I also understand that headaches were reported in half of the patients who participated in the clinical trial for the device. I understand that both discomfort and headaches got better over time in the research

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studies and that I may take common over-the counter pain medications such as acetaminophen (Tylenol) if a headache occurs.

H) The following risks are also with this treatment:

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

I) TMS Treatment is not effective for all patients with depression. Any signs or symptoms of worsening depression should be reported immediately to Dr. Gowda. You may want to ask a family member or caregiver to monitor your symptoms to help you spot any signs of worsening depression.

J) Seizures (sometimes called convulsions or fits) have been reported with the use of the other type of TMS devices. However, no seizures were observed with use of the TMS Treatment system in over 30,000 patient treatment sessions.

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

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

M) I understand that I may discontinue treatment at any time.

I have read the information contained in the Medical Procedure Consent Form about TMS Treatment and its potential risks. I have discussed with with Dr. Gowda, who have answered all of my questions. I understand there are other treatment options for my condition available to me and this has also been discussed with me. I understand that TMS is currently approved for depressed, however, the goal of my treatment would be off- label indications and this has been explained to me.

I, therefore, permit Dr. Srisai Gowda and his staff to administer this treatment to me.

Patient Name (Print): _____ Date: _____

Patients Signature: _____

Witness: _____