Texas TMS Center
3215 Steck Avenue, Suite 200
Tel. (512) 610-1111
Fax (512) 476-0195
www.texastmscenter.com

Texas TMS Center Patient Information

Thank you for your interest in our Deep Transcranial Magnetic Stimulation program. In preparation for your consultation, please review the attached information that should answer the majority of your questions.

This packet includes the following forms:

- Information about Deep TMS and our policies and procedures
- Patient Information Form
- Deep TMS Initial Evaluation Form
- Patient Safety Screening Form
- Acknowledgement of Receipt of Privacy Practices (Available for download on our website, www.texastmscenter.com)

The following information is necessary before a consultation can be scheduled:

1. Deep TMS Patient Information Form – please complete the attached Deep TMS Patient Information Form.

2. If possible, provide a referral letter from your treating physician to include:
   - Diagnosis
   - History of present psychiatric illness including current symptoms and length of episode
   - Psychiatric history including detailed list of prior medication trials, dosages and response, and past hospitalizations
   - Past medical history
   - Family psychiatric history

The above information should be faxed to (512) 476-0195 or emailed to our TMS Coordinator, Franzisca N. Uhrig, at fuhrig@texastmscenter.com. If you have any questions, please call our office at (512) 610-1111. Our office hours are Monday-Friday 9am-4:30pm except holidays.

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DEEP TMS PATIENT INFORMATION

What is Deep TMS?

Deep Transcranial Magnetic Stimulation (Deep TMS) is a noninvasive technique used to apply brief magnetic pulses to the brain. The pulses are administered by passing high currents through an electromagnetic coil placed adjacent to a patient's scalp. The pulses induce an electric field in the underlying brain tissue. When the induced field is above a certain threshold, and is directed in an appropriate orientation relative to the brains' neuronal pathways, the neurons in the relevant brain structure are activated. Deep TMS is based on magnetic resonance imaging (MRI) technology, which has been used clinically for over 20 years.

Is Deep TMS approved?
The Brainsway Deep TMS System is cleared by the Food and Drug Administration (FDA) for the treatment of depressive episodes in adult patients suffering from Major Depressive Disorder, **who failed to achieve satisfactory improvement from any number of previous anti-depressant medication or ECT treatments**.

What should I expect in a Deep TMS session?
Deep TMS is a treatment prescribed by a physician, usually a psychiatrist. Treatments are administered by a certified Deep TMS technician.

During the first Deep TMS treatment session, the technician will place the magnetic coil, which resembles a helmet, over the patient's head. To calibrate the intensity of Deep TMS an individual patient requires, the technician will stimulate the region of the patient's brain that makes the thumb move. Patients hear a clicking sound and feel a tapping sensation on the scalp. The device is adjusted to give just enough energy to send electromagnetic pulses into the brain, so that the thumb twitches. The intensity of stimulation that barely produces a movement is called the motor threshold (MT). Once the MT is determined, the magnetic coil will be moved to the location of the brain research suggests may be responsible for causing depression. How often a patient's MT is re-evaluated is determined by the physician who prescribes the treatment.

The treatment session is delivered as a series of pulses that last 2 seconds, with a rest period of 20 seconds between each pulse sequence, for a total of 1,980 pulses. Treatment is targeted to the region of the brain called the dorsolateral prefrontal cortex (DLPFC), or the left frontal part of the brain. Each treatment lasts approximately 20 minutes. The number of Deep TMS treatments prescribed will be determined by Dr. Winston, or one of his associates, at your initial evaluation. Dr. Winston, or one of his associates, meets with each patient weekly during the course of Deep TMS treatments to answer questions and coordinate treatment.

This treatment does not involve any anesthesia or sedation and patients remain awake and alert during the treatment. Patients are able to drive themselves to and from appointments. Throughout the course of treatment, patients are regularly evaluated by their healthcare provider.

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Benefits and advantages of Deep TMS

- The Texas TMS Center has over 8 years experience providing TMS and Deep TMS
- Non-invasive, out-patient treatment
- Statistically and clinically significant improvement in depression symptoms (Results from Brainsway double-blind trial reported 38% of patients responded and 33% remitted)
- Following your first treatment appointment which lasts 90 minutes, daily treatment appointments last approximately 30 minutes
- No anesthesia
- No adverse effects on cognition or memory
- Few or no side effects (most severe side effect is a headache, scalp discomfort). Less than 5% of patients discontinued treatment due to side effects.
- Patients do NOT have to stop taking medication in order to receive Deep TMS
- FDA approved since January 2013
- National Institutes of Health owns the patent to the Brainsway Deep TMS. TMS is included in the American Psychiatric Association's treatment guidelines for major depressive disorder

Am I a good candidate?

The best way for you to determine if Deep TMS is right for you, is to have a consultation with Dr. Winston or one of his associates. Proper pre-procedural screening ensures that therapy is administered only when it is medically advisable.

Eligibility:

Eligibility for Deep TMS therapy is determined during an evaluation with Dr. Winston or one of his associates. The following general requirements will need to be met prior to receiving Deep TMS therapy:

- No previous history of epilepsy unless stable on medication
- No foreign metal cranial bodies or metallic/magnetic implants above the shoulders

How often will I receive Deep TMS therapy?

Deep TMS treatments are administered daily over an average period of 6-9 weeks. The specific number of treatments for each individual patient will be determined by Dr. Winston, or one of his associates, based on individual response. The first treatment session will last 90 minutes, while we determine the best placement of the Deep TMS coil and provide the first treatment. Patients then receive a 20 minute treatment daily, from Monday to Friday, and each appointment takes approximately 30 minutes each day.

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Maintenance treatment: Maintenance treatment or booster treatments (at additional cost) may be required in the future depending upon your individual needs. You or your treating provider can contact us if maintenance treatment is required.

Do I continue to see my treating provider during the course of Deep TMS Therapy?

Yes. During your course of Deep TMS therapy, you will continue your regularly scheduled appointment(s) with your treating provider as they will continue to follow you and prescribe any of your ongoing medications if needed. We will be conferring with them while you are receiving Deep TMS Therapy.

Insurance Coverage and Reimbursement

Prior to your initial evaluation, you will be asked to send our office a copy of the front and back of your insurance card so that we may verify your individual policy coverage for the initial Deep TMS consultation and Deep TMS treatments. We will contact you prior to your initial appointment to review your coverage.

Cancellation policy:

In order for Deep TMS Therapy to be effective, it is important that you make all your scheduled sessions. Missing any treatments could affect your response and is not advisable. Only absolute emergencies and medical illness are acceptable reasons for cancellation. This is a serious treatment for a serious illness.

What happens next?

Once you have scheduled your initial consultation, please initial all pages in the lower right hand corner of this document. Complete the attached health history form and the patient safety screening form. Email these forms to our TMS Coordinator Ashley Carroll at acarroll@texastmscenter.com, or fax them to her attention at 512-476-0195. **This information should be submitted to our office at least 48 hours prior to your initial consultation appointment**.

Initial consultation will be a verbal consultation with the TMS Coordinator followed by Dr. Winston or one of his associates for a psychiatric evaluation.

Prior to Your First Deep TMS treatment:

You will be asked to sign consent forms and Dr. Winston or our TMS Coordinator will address any questions or concerns. Initial standardized depression rating scales will also be completed.

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POLICY & PROCEDURE

Payment Policy:

Due to the nature of the treatment we require each patient to determine the methodology for reimbursing our office for Deep TMS treatment. We offer a number of options: cash, check, credit card.

Depression Rating Forms:

As treatment continues, standardized depression scales will be repeated several times to monitor your progress.

Treatment:

Once treatment begins, you can take over the counter Extra Strength Tylenol (2 tablets) or up to 4- 200mg tablets of Ibuprofen ½ to 1 hour before your session, if not medically contraindicated for the individual person. During your first Deep TMS treatment, you will be made comfortable in the treatment room while we position the Deep TMS magnet and prepare the Deep TMS system. The helmet that holds the magnetic coil will be positioned on your head, so as best to treat the left front region of your head. The magnetic coil will make a clicking sound and you will be given earplugs to wear. The initial treatment session will last approximately 90 minutes. Remaining treatment sessions last approximately 30-45 minutes.

What happens at the end of your Deep TMS series?

Continued sessions:

We cannot predict how many exact treatments you will need. Dr. Winston, or one of his associates, will provide an initial prescription at your initial consultation. Treatment response is monitored weekly by Dr. Winston and he will discuss recommendations with you at your weekly appointment.

Discharge:

We will send a progress report to your treating provider.

Maintenance treatment or Booster Treatment:

In the future, you may require maintenance treatment or booster treatment (at additional cost) depending on your individual needs. You or your treating provider can call us if booster treatment is required.

I, _____acknowledge that I have read and accept the terms described in the Texas TMS Center New Patient Information.

_____ _____

Patient Signature Date

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date Completed:					
Name:		☐ M ☐ F	**DOB:**		
Address:					
Email Address:		**Social Security Number:**			
Home Phone:		**Cell Phone:**		**Work Phone:**	
May we leave a message at this number?	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
Emergency Contact:		**Relationship**:		**Phone Number:**	

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

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Surgeries

Year	Reason	Hospital

Psychiatric Diagnoses

Year	Diagnosis	Psychiatrist

Psychiatric Hospitalizations

Year	Reason	Hospital

Have you ever made a suicide attempt?	☐ Yes	☐ No	If yes, how many attempts have you made?		Please provide dates of all suicide attempts:	
Have you ever had an MRI?	☐ Yes	☐ No	Date:		Reason:	
Have you ever had a seizure?	☐ Yes	☐ No	Date:			

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FAMILY PSYCHIATRIC HISTORY

		AGE	PSYCHIATRIC DIAGNOSIS			AGE	PSYCHIATRIC DIAGNOSIS
Father				**Children**	☐ M ☐ F		
Mother					☐ M ☐ F		
Siblings	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F			***Grandmother*** *Paternal*			
	☐ M ☐ F			***Grandfather*** *Paternal*			

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Current Medications (Prescription and Over the Counter)		
Medication Name	Dose and Frequency Take	Date Started Medication

Allergies to medications	
Name the Drug	Reaction You Had

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PLEASE NOTE BELOW THE MEDICATIONS YOU HAVE TAKEN FOR <u>YOUR CURRENT EPISODE OF DEPRESSION</u>.

When did your <u>CURRENT</u> episode of depression begin (Month and Year – approximate if needed)?
Example: June 2017

PLEASE DO NOT LEAVE THIS SECTION BLANK, AS TREATMENT RECOMMENDATIONS AND INSURANCE COVERAGE GUIDELINES WILL REQUIRE THIS INFORMATION.

Past Psychiatric Medications

Name of Medication and Dose	Start and Stop Date	Outcome (Did this medication help your symptoms?). Please note any side effects.
Example: Wellbutrin XL 300mg	*April 1, 2016 - June 30, 2016*	*Worked at first, then stopped working after a few months*
Example: Zoloft 50mg	*July 1-2016 - July 25, 2016*	*Side Effects: Headaches*

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HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
Substance Abuse Treatment	Have you ever received treatment for substance (alcohol or drug) abuse or dependence?				☐ Yes	☐ No
	If so, please list the treatment provider/facility and dates:				Dates	
Immunizations	Have you had a Influenza (FLU) shot this season (Between October-March of the current year): **If so, approximate date of FLU shot was:_____**				☐ Yes	☐ No
Falls	Have you: _____Fallen more than once in the past 12 months? _____Fallen once with injury? _____Not fallen in the last 12 months					

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Patient Safety Screening Form

Print Name:_____

TMS therapy is contraindicated in patients who wear certain objects or devices. Some objects are not contraindicated, but we do need to be aware that you have them so that we can better protect you.

Please indicate if you have any of the following:

Aneurysm clips or coils in the head	o Yes	o No
History of Seizures or Epilepsy	o	o
Radioactive seeds	o Yes	o No
Carotid or cerebral stents	o Yes	o No
Magnetically programmable shunt valves	o Yes	o No
DBS electrodes	o Yes	o No
Metallic devices implanted in the head	o Yes	o No
Magnetically activated dental implants	o Yes	o No
Cochlear/otologic implants	o Yes	o No
CSF shunt	o Yes	o No
Ferromagnetic ocular implants	o Yes	o No
Pellets, bullets, fragments	o Yes	o No
Facial tattoos with metallic ink	o Yes	o No
Permanent makeup	o Yes	o No
Staples, sutures	o Yes	o No
VeriChip microtransponder	o Yes	o No
Cardiac Pacemaker	o Yes	o No
Cardiac Stents, filters, valves	o Yes	o No
Vagus Nerve Stimulator	o Yes	o No
Wearable infusion pumps	o Yes	o No
Implanted insulin pump	o Yes	o No
Single-Tooth Posts	o Yes	o No
Metal dental braces	o Yes	o No
Non-removable bridgework	o Yes	o No
Conductive maxillofacial reconstruction hardware	o Yes	o No
Titanium Skull plates	o Yes	o No
Cervical Fixation Device/Cervical Plate	o Yes	o No

If you wear any of the following, please remove before treatment:

____Eyeglasses
____Hearing Aids
____Wearable monitors
____Bone Growth Stimulators
____Removable dentures/bridgework

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____

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Rev. 4-2019

Jaron Winston, M.D.
3215 Steck Avenue
Suite 200
Austin, Texas 78757
512-610-1111

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of Dr.
(patient name)

Winston's Notice of Privacy Practices.

_____ _____
(signature of patient) (date)

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Consent for Evaluation

Jaron L. Winston, M.D. or one of his associates will be evaluating you for possible treatment with Deep Transcranial Magnetic Stimulation.

I understand that this is just an evaluation and that I might not be a candidate for Deep TMS.

I understand that this service may be covered by insurance on a case by case basis.

I also understand that I will be responsible for the total cost of this evaluation.

If required, The Texas TMS Center will present me with a copy of my receipt so I may file with my insurance company.

Print Name: _____

Signature: _____ _____

Date

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