Consent for TMS treatment

This form explains the TMS treatment proposed for me, its possible benefits and risks, and the other options available to me. My treating team will discuss it with me before I decide.

My practice and treatment

Practice name

Treating clinician

Practice phone or contact details

Client name

Date of birth

TMS manufacturer and model

Coil and treatment protocol

Condition being treated

Patient manual title and version

Understanding my treatment

TMS stands for transcranial magnetic stimulation. A treatment coil produces pulsed magnetic fields that stimulate nerve cells in a targeted area of the brain. My treating team has explained the device and protocol proposed for me.

My practice will provide the patient manual for my device. I understand that this form does not replace that manual or my conversation with my clinician. I can ask questions before, during or after treatment.

Treatment target and purpose

How this device and protocol apply to my condition

What to expect during treatment

My treating team will position me and the treatment coil as required for my device. I may hear clicks and feel tapping on my scalp. TMS does not require anesthesia or sedation, so I will remain awake during treatment.

If my protocol uses a motor threshold measurement, my team will explain it. This measurement helps determine treatment settings. My clinician will decide when to repeat it and will explain my treatment settings.

Proposed visit length and treatment schedule

How treatment settings and any pauses are determined

Safety information to share with my team

Before treatment, I will tell my team about implanted devices, metal in my head or body, and any past procedures that may have left metal behind. Magnetic fields can affect some implants or metal objects and may cause serious injury. My clinician will check the restrictions for my device.

I will tell my team about seizures, neurological conditions, head injuries and all medications I take. I will also report changes in my health or medications during treatment so my clinician can reassess my safety.

Device specific restrictions and precautions discussed with me

Hearing protection

TMS produces loud clicks. I will use the hearing protection my treating team provides according to the instructions for my device. I will tell the team if it does not fit or if I notice hearing changes.

Hearing protection required for my device

Benefits risks and other options

Possible benefits

The goal is to improve the symptoms described in my treatment plan. My response and the time it takes to notice a change may vary. No one has guaranteed that TMS will improve my symptoms.

Expected benefits and limits discussed with me

Possible risks and discomfort

TMS may cause scalp discomfort or a headache. I will tell my treating team if I feel pain or discomfort. My clinician will explain what can be adjusted and how to manage symptoms safely.

A seizure can occur during TMS. My clinician has discussed this risk with me and reviewed factors that may affect it. Hearing injury is also a risk, which is why the required hearing protection matters.

My clinician has explained the additional risks, warnings and uncertainties that apply to my device, treatment protocol and health history.

Additional risks warnings and uncertainties discussed with me

Other treatment options

My clinician has discussed the alternatives appropriate for my condition, including what may happen if I decide not to have TMS. I have had the opportunity to ask how these options compare.

Alternatives and the option not to receive TMS

My choice and consent

I have read this form and had the opportunity to review the patient manual. My treating team has explained the proposed treatment, possible benefits, risks, restrictions and alternatives in a way I understand. My questions have been answered.

My choice is voluntary. I may ask questions or decide to stop treatment at any time. I understand that results are not guaranteed.

Emergency care

If a medical emergency occurs during treatment, I authorize the treating staff to provide or arrange emergency care they judge necessary.

My authorization

I authorize the practice named on this form and its treating team to provide the TMS treatment described here. If this form does not relate to my planned care, I will contact the practice rather than sign it.

When I sign in Allia, my electronic signature and signing date are recorded there with this form.

Client name

Date

Client signature