Psychiatry Delaware

1415 Foulk Rd Ste. 104

Wilmington, DE 19803

Phone #302-478-1450

Fax #302-478-1430

Patient Name:

DOB:

TMS Patient Screening Form

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

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
Deep brain stimulator	☐Yes	☐No	Cervical fixation devices	☐Yes	☐No
Metallic devices implanted in your head	☐Yes	☐No	Surgical clips, staples, or sutures	☐Yes	☐No
Dental implants	☐Yes	☐No	VeriChip microtransponder	☐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	Portable glucose monitor	☐Yes	☐No
Vagus nerve stimulator (VNS)	☐Yes	☐No	Tracheostomy	☐Yes	☐No
Blood vessel coil	☐Yes	☐No	Medication patch/nicotine patch	☐Yes	☐No
Shrapnel, bullets, pellets, BBs, or other metal fragments	☐Yes	☐No	Other implanted metal or device If yes, please specify:_____	☐Yes	☐No

Age: _____ Weight (lbs): _____ Height: _____ Last menstrual period: _____

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

Signature of person completing this form: _____ Date: _____

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

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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rTMS INFORMATION

My doctor has recommended that I receive treatment with repetitive transcranial magnetic stimulation (rTMS).

WHAT IS rTMS ?

rTMS stands for "repetitive transcranial magnetic stimulation." rTMS is a non-invasive FDA-cleared medical procedure for the treatment of depression in adults. rTMS is a brain stimulation technique that relies on the generation of brief magnetic fields using an insulated coil that is placed over the scalp. These magnetic fields are the same type and strength as those used in magnetic resonance imaging (MRI) machines. The magnetic pulses generate a weak electrical current in the brain that briefly activates neural circuits at the stimulation site. rTMS has been shown to be a safe and well-tolerated procedure that can be an effective treatment for adult patients with depression who have not benefitted from antidepressant treatment.

The potential benefit of rTMS is that it may lead to improvements in the symptoms of my psychiatric condition. I understand that not all patients respond equally well to rTMS. Like all forms of medical treatment, some patients recover quickly, others recover briefly and later relapse, while others may fail to have any response to rTMS therapy.

ALTERNATIVES TO rTMS

I understand that there are alternative treatment options for my condition, including medications, psychotherapy, and electroconvulsive therapy (ECT). My doctor has explained to me the risks and benefits of these other options. My doctor has also explained why rTMS has been recommended for my specific case.

PROCEDURE

rTMS therapy involves a series of treatments. For each rTMS session, I will be brought into a specially equipped room in the hospital and seated in the treatment chair. Before beginning the rTMS procedure, I will be asked to remove any metal or magnetic-sensitive objects (e.g., jewelry, keys, credit cards). Because rTMS produces a loud clicking sound with each pulse, I will also be required to wear earplugs for my comfort and safety. rTMS does not require any anesthesia or sedation, so I will be awake and alert during the entire procedure.

The insulated magnetic coil will be gently placed over the side or on top of my head. The TMS staff member will then adjust the TMS device by delivering a series of pulses until it gives just enough energy so that my 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. During the procedure, I will hear a clicking sound and feel a tapping sensation on my scalp.

Once my motor threshold is determined, the magnetic coil will be moved to the front side of my head, over a region of the brain that scientists think may be responsible for causing depression. I will receive the treatment as a

series of "pulses," with a "rest" period between each pulse series. Treatment sessions typically last thirty to forty minutes.

Trained staff will be monitoring me during the entire treatment. I may stop the procedure at any time.

NUMBER OF TREATMENTS

The exact number of treatments I receive cannot be predicted ahead of time. The number of treatments I receive will depend on my psychiatric condition, my response to treatment, and the medical judgment of my psychiatrist. rTMS treatments are usually administered five times per week, but the frequency of my treatments may vary depending on my needs. Typically, patients who respond to rTMS experience results by the fourth to sixth week of treatment. However, some patients may experience results in less time while others may take longer. I may choose to end the treatments at any time.

RISKS

As with any medical treatment, rTMS carries a risk of side effects. However, rTMS is generally well-tolerated and only a small percentage of patients discontinue treatment because of side effects.

During the treatment, I may experience tapping, facial twitching, or painful sensations at the treatment site while the magnetic coil is turned on. These types of sensations are reported by about one third of patients. I understand that I should inform staff if this occurs. The treatment staff may then adjust the stimulation settings or make changes to where the coil is placed in order to help make the procedure more comfortable for me. In addition, about half of patients treated with rTMS experience headaches. I understand that both discomfort and headaches tend to get better over time and that the headaches generally responded very well to over-the-counter pain medications.

Because the TMS device produces a loud click with each pulse, I understand that I must wear earplugs during treatment to minimize the risk of hearing loss. There have been no reported cases of permanent hearing loss with properly functioning hearing protection. If I notice that my earplugs become loose or have fallen out, I will notify treatment staff immediately.

As with all antidepressant treatments, there is a small risk for the emergence of mania with rTMS therapy. My doctor has informed me of these symptoms and will monitor me for the development of these symptoms. If I notice these symptoms, I will alert my doctor immediately.

The most serious known risk of rTMS is the production of a seizure. Although there have been a few case reports of seizures with the use of TMS devices, this risk is extremely small. Nonetheless, I will let my doctor know if I have a history of a seizure disorder, as it may influence my risk of developing a seizure with this procedure. The TMS team follows up-to-date safety guidelines for the use of TMS that are designed to minimize the risk of seizures with this technique.

rTMS therapy is not effective for all patients with depression, and there is a risk that my depression will get worse. 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.

There are no known adverse cognitive (thinking and memory) effects associated with rTMS therapy.

PREGNANCY

The risks of exposure to TMS in pregnancy are unknown. If I am a woman of childbearing capacity, I may be asked to take a pregnancy test before starting treatment.

LONG-TERM ADVERSE EFFECTS

There are no known long-term adverse effects reported with the use of rTMS. However, as this is a relatively new treatment, there may be unforeseen risks in the long-term that are currently unknown.

METAL IMPLANTS

TMS should not be used by anyone who has non-removable magnetic-sensitive metal in their head or within twelve inches of the magnetic coil. 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 in your neck or brain
- Implanted stimulators
- Cardiac pacemakers or implantable cardioverter defibrillator (ICD)
- Cardiac stents
- Electrodes to monitor your brain activity
- Metallic implants in your ears or eyes
- Shrapnel or bullet fragments
- Facial tattoos with metallic or magnetic-sensitive ink
- Other metal devices or objects implanted in or near your head

FURTHER QUESTIONS

I understand that I should feel free to ask questions of my doctor or member of the TMS team about rTMS at this time or any time during or after the course of my treatment. I understand that my decision to agree to rTMS is being made on a voluntary basis and that I may withdraw my consent and have the treatments stopped at any time.

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rTMS CONSENT

I have read (or have had read to me) the information contained in this consent form about rTMS therapy and its potential risks and benefits for the treatment of my diagnosis of _____. I acknowledge that Dr._____ has explained the purpose of the procedure, the potential risks and benefits of the procedure, and the alternatives to rTMS. All my questions regarding the procedure have been answered to my satisfaction. I understand there are other treatment options for my condition available to me and this has also been discussed with me.

If during the course of treatment other conditions arise which, in the best judgment of the medical staff, require emergency treatment, I authorize and request the said treatment be performed. I further understand that no guarantee of any results has been made.

I consent to the admission of medical students and other authorized observers during the treatments, in accordance with ordinary practices of Psychiatry Delaware.

I therefore authorize and request the staff of Psychiatry Delaware to administer a course of rTMS treatments to me.

I have read carefully, and I understand, the foregoing.

_____	_____	_____
Signature of Patient:	Signature of Witness:	Date:

_____

Signature of Physician/Health Care Provider Securing Consent:

Hamilton Depression Rating Scale (HDRS)

Reference: **Hamilton M. A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–62**

Rating Clinician-rated

Administration time 20–30 minutes

Main purpose To assess severity of, and change in, depressive symptoms

Population Adults

Commentary

The HDRS (also known as the Ham-D) is the most widely used clinician-administered depression assessment scale. The original version contains 17 items ($HDRS_{17}$) pertaining to symptoms of depression experienced over the past week. Although the scale was designed for completion after an unstructured clinical interview, there are now semi-structured interview guides available. The HDRS was originally developed for hospital inpatients, thus the emphasis on melancholic and physical symptoms of depression. A later 21-item version ($HDRS_{21}$) included 4 items intended to subtype the depression, but which are sometimes, incorrectly, used to rate severity. A limitation of the HDRS is that atypical symptoms of depression (e.g., hypersomnia, hyperphagia) are not assessed (see SIGH-SAD, page 55).

Scoring

Method for scoring varies by version. For the $HDRS_{17}$, a score of 0–7 is generally accepted to be within the normal range (or in clinical remission), while a score of 20 or higher (indicating at least moderate severity) is usually required for entry into a clinical trial.

Versions

The scale has been translated into a number of languages including French, German, Italian, Thai, and Turkish. As well, there is an Interactive Voice Response version (IVR), a Seasonal Affective Disorder version (SIGH-SAD, see page 55), and a Structured Interview Version (HDS-SIV). Numerous versions with varying lengths include the HDRS17, HDRS21, HDRS29, HDRS8, HDRS6, HDRS24, and HDRS7 (see page 30).

Additional references

Hamilton M. Development of a rating scale for primary depressive illness. Br J Soc Clin Psychol 1967; 6(4):278–96.

Williams JB. A structured interview guide for the Hamilton Depression Rating Scale. Arch Gen Psychiatry 1988; 45(8):742–7.

Address for correspondence

The HDRS is in the public domain.

Hamilton Depression Rating Scale (HDRS)

PLEASE COMPLETE THE SCALE BASED ON A STRUCTURED INTERVIEW

Instructions: for each item select the one "cue" which best characterizes the patient. Be sure to record the answers in the appropriate spaces (positions 0 through 4).

1 DEPRESSED MOOD *(sadness, hopeless, helpless, worthless)*

- 0 ☐ Absent.
- 1 ☐ These feeling states indicated only on questioning.
- 2 ☐ These feeling states spontaneously reported verbally.
- 3 ☐ Communicates feeling states non-verbally, i.e. through facial expression, posture, voice and tendency to weep.
- 4 ☐ Patient reports virtually only these feeling states in his/her spontaneous verbal and non-verbal communication.

2 FEELINGS OF GUILT

- 0 ☐ Absent.
- 1 ☐ Self reproach, feels he/she has let people down.
- 2 ☐ Ideas of guilt or rumination over past errors or sinful deeds.
- 3 ☐ Present illness is a punishment. Delusions of guilt.
- 4 ☐ Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations.

3 SUICIDE

0 |__| Absent.
1 |__| Feels life is not worth living.
2 |__| Wishes he/she were dead or any thoughts of possible death to self.
3 |__| Ideas or gestures of suicide.
4 |__| Attempts at suicide (any serious attempt rate 4).

4 INSOMNIA: EARLY IN THE NIGHT

0 |__| No difficulty falling asleep.
1 |__| Complains of occasional difficulty falling asleep, i.e. more than ½ hour.
2 |__| Complains of nightly difficulty falling asleep.

5 INSOMNIA: MIDDLE OF THE NIGHT

0 |__| No difficulty.
1 |__| Patient complains of being restless and disturbed during the night.
2 |__| Waking during the night – any getting out of bed rates 2 (except for purposes of voiding).

6 INSOMNIA: EARLY HOURS OF THE MORNING

0 |__| No difficulty.
1 |__| Waking in early hours of the morning but goes back to sleep.
2 |__| Unable to fall asleep again if he/she gets out of bed.

7 WORK AND ACTIVITIES

0 |__| No difficulty.
1 |__| Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies.
2 |__| Loss of interest in activity, hobbies or work – either directly reported by the patient or indirect in listlessness, indecision and vacillation (feels he/she has to push self to work or activities).
3 |__| Decrease in actual time spent in activities or decrease in productivity. Rate 3 if the patient does not spend at least three hours a day in activities (job or hobbies) excluding routine chores.
4 |__| Stopped working because of present illness. Rate 4 if patient engages in no activities except routine chores, or if patient fails to perform routine chores unassisted.

8 RETARDATION (slowness of thought and speech, impaired ability to concentrate, decreased motor activity)

0 |__| Normal speech and thought.
1 |__| Slight retardation during the interview.
2 |__| Obvious retardation during the interview.
3 |__| Interview difficult.
4 |__| Complete stupor.

9 AGITATION

0 |__| None.
1 |__| Fidgetiness.
2 |__| Playing with hands, hair, etc.
3 |__| Moving about, can't sit still.
4 |__| Hand wringing, nail biting, hair-pulling, biting of lips.

10 ANXIETY PSYCHIC

0 |__| No difficulty.
1 |__| Subjective tension and irritability.
2 |__| Worrying about minor matters.
3 |__| Apprehensive attitude apparent in face or speech.
4 |__| Fears expressed without questioning.

11 ANXIETY SOMATIC (physiological concomitants of anxiety) such as:

gastro-intestinal – dry mouth, wind, indigestion, diarrhea, cramps, belching
cardio-vascular – palpitations, headaches
respiratory – hyperventilation, sighing
urinary frequency
sweating

0 |__| Absent.
1 |__| Mild.
2 |__| Moderate.
3 |__| Severe.
4 |__| Incapacitating.

12 SOMATIC SYMPTOMS GASTRO-INTESTINAL

0 |__| None.
1 |__| Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
2 |__| Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for gastro-intestinal symptoms.

13 GENERAL SOMATIC SYMPTOMS

0 |__| None.
1 |__| Heaviness in limbs, back or head. Backaches, headaches, muscle aches. Loss of energy and fatigability.
2 |__| Any clear-cut symptom rates 2.

14 GENITAL SYMPTOMS (symptoms such as loss of libido, menstrual disturbances)

0 |__| Absent.
1 |__| Mild.
2 |__| Severe.

15 HYPOCHONDRIASIS

0 |__| Not present.
1 |__| Self-absorption (bodily).
2 |__| Preoccupation with health.
3 |__| Frequent complaints, requests for help, etc.
4 |__| Hypochondriacal delusions.

16 LOSS OF WEIGHT ***(RATE EITHER a OR b)***

	a) According to the patient:	**b) According to weekly measurements:**
0	|__| No weight loss.	0 |__| Less than 1 lb weight loss in week.
1	|__| Probable weight loss associated with present illness.	1 |__| Greater than 1 lb weight loss in week.
2	|__| Definite (according to patient) weight loss.	2 |__| Greater than 2 lb weight loss in week.
3	|__| Not assessed.	3 |__| Not assessed.

17 INSIGHT

0 |__| Acknowledges being depressed and ill.
1 |__| Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 |__| Denies being ill at all.

Total score: |__|__|

Hamilton Anxiety Rating Scale (HAM-A)

Reference: **Hamilton M. The assessment of anxiety states by rating. Br J Med Psychol 1959; 32:50–55.**

Rating Clinician-rated

Administration time 10–15 minutes

Main purpose To assess the severity of symptoms of anxiety

Population Adults, adolescents and children

Commentary

The HAM-A was one of the first rating scales developed to measure the severity of anxiety symptoms, and is still widely used today in both clinical and research settings. The scale consists of 14 items, each defined by a series of symptoms, and measures both psychic anxiety (mental agitation and psychological distress) and somatic anxiety (physical complaints related to anxiety). Although the HAM-A remains widely used as an outcome measure in clinical trials, it has been criticized for its sometimes poor ability to discriminate between anxiolytic and antidepressant effects, and somatic anxiety versus somatic side effects. The HAM-A does not provide any standardized probe questions. Despite this, the reported levels of inter-rater reliability for the scale appear to be acceptable.

Scoring

Each item is scored on a scale of 0 (not present) to 4 (severe), with a total score range of 0–56, where <17 indicates mild severity, 18–24 mild to moderate severity and 25–30 moderate to severe.

Versions

The scale has been translated into: Cantonese for China, French and Spanish. An IVR version of the scale is available from Healthcare Technology Systems.

Additional references

Maier W, Buller R, Philipp M, Heuser I. The Hamilton Anxiety Scale: reliability, validity and sensitivity to change in anxiety and depressive disorders. J Affect Disord 1988;14(1):61–8.

Borkovec T and Costello E. Efficacy of applied relaxation and cognitive behavioral therapy in the treatment of generalized anxiety disorder. J Clin Consult Psychol 1993; 61(4):611–19

Address for correspondence

Hamilton Anxiety Rating Scale (HAM-A)

Below is a list of phrases that describe certain feeling that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions. Select one of the five responses for each of the fourteen questions.

0 = Not present, 1 = Mild, 2 = Moderate, 3 = Severe, 4 = Very severe.

1 Anxious mood [0] [1] [2] [3] [4]

Worries, anticipation of the worst, fearful anticipation, irritability.

2 Tension [0] [1] [2] [3] [4]

Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.

3 Fears [0] [1] [2] [3] [4]

Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.

4 Insomnia [0] [1] [2] [3] [4]

Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.

5 Intellectual [0] [1] [2] [3] [4]

Difficulty in concentration, poor memory.

6 Depressed mood [0] [1] [2] [3] [4]

Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.

7 Somatic (muscular) [0] [1] [2] [3] [4]

Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.

8 Somatic (sensory) [0] [1] [2] [3] [4]

Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.

9 Cardiovascular symptoms [0] [1] [2] [3] [4]

Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.

10 Respiratory symptoms [0] [1] [2] [3] [4]

Pressure or constriction in chest, choking feelings, sighing, dyspnea.

11 Gastrointestinal symptoms [0] [1] [2] [3] [4]

Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.

12 Genitourinary symptoms [0] [1] [2] [3] [4]

Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.

13 Autonomic symptoms [0] [1] [2] [3] [4]

Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.

14 Behavior at interview [0] [1] [2] [3] [4]

Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc.