Northamptonshire Healthcare NHS
NHS Foundation Trust

rTMS Patient Screening Form

This should be completed by the patient / patient representative.
Please complete the following information:

	Please Tick	
	Yes	No
1. Have you had rTMS before and had any adverse effects?		
2. Do you have epilepsy or ever had a convulsion or a seizure?		
3. Does anyone in your family suffer from epilepsy?		
4. Have you ever had a stroke?		
5. Have you ever had a serious head injury? (Including loss of consciousness, neurosurgery or a brain related condition or illness that caused brain injury?)		
6. Have you ever had an electroencephalogram (EEG)?		
7. Have you ever been a machinist, welder or metal worker?		
8. Have you ever had a facial injury from metal / metal removed from Your eyes?		
9. Have you ever had complications from an MRI?		
10. Have you had any surgery in the last 12 months above the neck?		
11. Have you ever had a surgical procedure to your spinal cord?		
12. Do you have spinal problems?		
13. Do you have a history of fainting?		
14. Do you suffer from frequent headaches?		
15. Do you have any hearing problems or ringing in your ears? (Advise earplugs must be worn as possible risk of temporary tinnitus)		
16. Do you have a medication infusion device?		
17. Are you taking prescribed medication or recreational drugs? Please specify:		
18. Are you pregnant? (N.B. Complete pregnancy test for women of childbearing age)		
19. Last Menstrual Period?	Date:	
20. How much alcohol do you drink in an average week?	Units:	

Height:	Weight:	BMI:

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Have you ever had or currently have the following:	Please tick	
	Yes	No
1. Aneurysm clips or coils		
2. Cardiac pacemaker or wires		
3. Internal cardioverter defibrillator (ICD)		
4. Carotid or cerebral stents		
5. Deep brain stimulator		
6. Metallic devices implanted in your head		
7. Dental implants		
8. Cochlear implants/ear implants		
9. CSF (cerebrospinal fluid) shunt		
10. Eye Implants		
11. Cardiac stents, filters or metallic valves		
12. Tattoo		
13. Vagus nerve stimulator (VNS)		
14. Blood vessel coil		
15. Shrapnel, bullets, pellets, BBs, other metal fragments		
16. Wearable cardioverter defibrillator		
17. Implanted insulin pump		
18. Programmable shunt or valve		
19. Hearing aid		
20. Cervical fixation devices		
21. Surgical clips, staples or sutures		
22. VeriChip microtransponder		
22. Wearable monitor (e.g. heart monitor)		
23. Bone growth stimulator		
24. Wearable infusion pump		
25. Radioactive seeds		
26. Portable glucose monitor		
27. Tracheostomy		
28. Medication patch/nicotine patch		
Other implanted metal or device If yes please specify ……..		
If you have answered ‘yes’ to any of the above please provide further information:		

Signature of patient/patient representative……. Date…..……

Signature of Consultant Psychiatrist/rTMS Lead Nurse……..…… Date……..……