Please use ID label or block print

EMR209045

SOUTH METROPOLITAN HEALTH SERVICE

REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (rTMS) SCREENING TOOL

WARD: _____

DOCTOR: _____

SURNAME	URN
GIVEN NAMES	
ADDRESS	
D.O.B.	SEX

What is the indication for rTMS treatment?

☐ Depression ☐ Other: _____

Please answer the following questions

Have you undergone rTMS in the past?	☐ Yes ☐ No
If yes, were there any adverse reactions?	☐ Yes ☐ No
Have you ever had a convulsion / fits / seizure?	☐ Yes ☐ No
Does any of your family have epilepsy?	☐ Yes ☐ No
Have any of your family had a fainting spell or syncope?	☐ Yes ☐ No
Do you have a history of head injury / neurosurgery? If yes, was this associated with concussion or loss of consciousness?	☐ Yes ☐ No
Do you have any metal in the brain, skull or anywhere else in your body such as shrapnel, surgical clips, splinters or fragments from welding or metal works? If yes, please specify the position in the body	☐ Yes ☐ No
Do you have a cardiac pacemaker or intracardiac lines?	☐ Yes ☐ No
Do you have a medication infusion device?	☐ Yes ☐ No
Do you have an implanted neurostimulator eg DBS, epidural / subdural, VNS?	☐ Yes ☐ No
Do you have any hearing problems?	☐ Yes ☐ No
Do you have cochlear implants?	☐ Yes ☐ No
Do you suffer from frequent / severe headaches?	☐ Yes ☐ No
Have you ever had any other brain related condition?	☐ Yes ☐ No
Are you pregnant?	☐ Yes ☐ No
Are you a professional driver?	☐ Yes ☐ No
Do you have facial tattoos with metallic or magnetic sensitive ink?	☐ Yes ☐ No
Do you have dental implants? If yes, Specify:	☐ Yes ☐ No
Have you ever had an EEG? (brain scan) If yes, please state the reason below:	☐ Yes ☐ No
Have you ever undergone an MRI of your head in the past? If yes, were there any issues? Please describe below:	☐ Yes ☐ No

SMR002 rTMS SCREENING TOOL

SMR002
06/26

Please use ID label or block print

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WARD: _____

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Using drug and alcohol may negatively impact your treatment. For us to safely provide treatment, we need to ask the following questions.

Do you drink alcohol? ☐ Yes ☐ No

If yes, please specific below:
(A standard drink = 100mls wine, 30ml spirit, 1 mid-strength beer)

Amount consumed	How often	Last Consumed

Do you use any other substances, including non-prescribed or not as prescribed? ☐ Yes ☐ No

If yes, please list them here:

Type of drug	Amount consumed	How often	Last Used

Any change of medical history since your last visit? (not applicable for new rTMS patients) ☐ Yes ☐ No

If yes, please provide details below:

I _____ (print name) acknowledge that to the best of my knowledge the above answers relating to the safety of the rTMS treatment are accutrate.

Signature: _____ Date: _____

GP: Please attached this screening tool to the referral form and email to: FH.TMS@health.wa.gov.au
Internal Referral: Please complete TMS e-referral and attach this completed form to the e-referral

☐ Accepted ☐ Not accepted ☐ Refer notified

Comments:

Name: _____ Signature: _____ Date: _____