The rTMS Centre
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Screening Form

Full Name:
Date of Birth:
Address:

General Practitioner contact details (address) :

Male / Female **Age: .....**

Are you pregnant? **Yes No N/A**

Section 1: Technical Questions

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**
Vagus nerve stimulator (VNS)	**Yes No**	Portable glucose monitor	**Yes No**
Blood vessel coil	**Yes No**	Tracheostomy	**Yes No**
Medication patch/nicotine patch	**Yes No**	Other implanted metal or device If yes, please specify:_____	

Have you ever had complication from an MRI? .....

Section 2: Clinical Questions.

1) Are you affected by Depression/Anxiety (please specify - Unipolar etc)?
……
(i) How many months and/or years? ……

2) Are you currently taking medication for depression/Anxiety? **Yes** **No**
(i) Please specify brand/name of medication for clinical depression/Anxiety?
……

(ii) How many different medications for depression/Anxiety taken?
……

3) Do you have epilepsy? **Yes** **No** ……

4) Have you experienced a seizure within the last 12 months? **Yes** **No**
(i) How long did the episode last?..... ……
(ii)Do you suffer from migraines and/or continuous headaches?
……

5) Do you suffer from Insomnia? **Yes** **No**
……..

6) Daily alcohol intake:
7) Daily Caffeine intake:
8) Drug Abuse:

9) Are you currently on any other medication other than anti-depressants? Please specify.
……

Other relevant information:
……
……

Signature of person filling this form:
…….…… Date:……