SAFETY CHECKLIST FOR TRANSCRANIAL MAGNETIC STIMULATION

Patient Identification:

For any question with a YES answer, please provide details in the space below.

1. Does the patient have epilepsy, or ever had seizures?      YES  NO
   Epilepsy is an absolute contraindication
   Recent seizures are a relative contraindication

2. Do any of the patient’s relatives have epilepsy?      YES  NO
   Epilepsy amongst first degree relatives is a relative contraindication

3. Does the patient have any metal implants in their body or head
   (other than dental work)        YES  NO
   Metal implants in the head are an absolute contraindication, below shoulders is acceptable

4. Does the patient have any implanted electronics?     YES  NO
   (cardiac pacemaker, defibrillator, cochlear implant, medication pump)
   Implanted electronics are absolute contraindications

5. Does the patient experience recurring headaches?      YES  NO
   Recurrent headaches of no known cause that do not respond to over the counter medications
   are a relative contraindication

6. Has the patient had a skull fracture or serious head injury?        YES  NO
   Skull fracture and serious head injury are absolute contraindications
7. Has the patient ever had head or brain surgery?  
*YES*  *NO*  
*Brain surgery is an absolute contraindication*

8. Is there any chance the patient could be pregnant?  
*YES*  *NO*  
*Pregnancy is an absolute contraindication*

9. Please list their current medications  
*Medications that lower seizure threshold are relative contraindications*

10. Please outline the patient’s previous medical history

Checklist completed by:  

________________________  

*Name*  

________________________  

*Signature*  

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*Date*

TMS approved by:  

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*Name*  

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*Signature*  

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*Date*