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:

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Name

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Signature

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Date

TMS approved by:

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Name

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Signature

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Date