Pinnacle Behavioral Healthcare
Exceptional Care, Compassionate People!

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TMS PATIENT SAFETY SCREENING FORM

Patient_____DOB: _____Date: _____

This is to be filled out by the PATIENT/ Patient Representative

Please indicate if you have any of the following:

Aneurysms clips or coils in the head	Yes	No			
Carotid or Cerebral Stents	Yes	No	Radioactive Seeds	Yes	No
Magnetically programmable shunts or valves	Yes	No	Wearable Cardioverter Defibrillator	Yes	No
Deep Brain Stimulator (DBS) or electrodes	Yes	No	Programmable Glucose Monitor	Yes	No
Metallic Devices implanted in the head	Yes	No	Cerebral Spinal Fluid (CFS) Shunt	Yes	No
Magnetically activated dental implants	Yes	No	Surgical Clips, staples, sutures	Yes	No
Bullets, pellets, shrapnel, BB's, metal fragments	Yes	No	Medication Patch/Nicotine Patch	Yes	No
Ferromagnetic ocular (eye) implants	Yes	No	Cochlear, otologic (ear) implants	Yes	No
Facial Tattoos with metallic ink	Yes	No	Tracheostomy	Yes	No
Body Tattoos	Yes	No	Permanent makeup	Yes	No
VeriChip microtransponder	Yes	No	Blood Vessel Coil	Yes	No
Cardiac Pacemaker or wires	Yes	No	Internal Cardioverter defibrillator (ICD)	Yes	No
Vagus Nerve Stimulator (VNS)	Yes	No	Cardiac Stents, filters, valves	Yes	No
Implanted Insulin pump	Yes	No	Wearable Infusion pumps	Yes	No
Metal dental braces	Yes	No	Single-Tooth Posts	Yes	No
Conductive maxillofacial reconstruction hardware	Yes	No	Non-removable bridgework	Yes	No
Cervical Fixation device/ Cervical Plate/screws	Yes	No	Titanium Skull Plates	Yes	No
Dental Implants	Yes	No	History of Seizure(s)	Yes	No
Implanted Venous access device/ports	Yes	No	Seizure Disorder	Yes	No

Other implanted/ wearable metal or Device. If yes, please specify: _____

Have you ever been a machinist, welder, metal worker?	Yes	No
Have you ever had a facial injury from metal and/or metal removed from your eyes?	Yes	No
Are you pregnant?	Yes	No
Have you ever had complications from a MRI	Yes	No

Age: _____ Weight: _____ Height_____ Last menstrual period_____

Allergies: _____

We ask that you remove any of the following objects during treatment: (Please bring your own container/ tray)

Eye glasses	Yes	No	Wearable monitors	Yes	No
Bone Growth stimulators	Yes	No	Hearing Aids	Yes	No
Removable dentures/bridgework	Yes	No	Jewelry (neck and above)	Yes	No
Hair Accessories	Yes	No	Wigs/ Hair Pieces	Yes	No

Notes: _____
_____

Signature of patient/person completing this form: _____ Date: _____

Signature of physician: _____ Date: _____