

## Office Policies and Treatment Consent

Welcome to our Pelorus TMS, specializing primarily in major depression treatment for those who have not responded to multiple anti-depressant medication trials. We thought it would be helpful to spell out some details, to avoid any confusion. Our goal is to help you (or your loved one) feel better, while realizing that no honest person can predict the future or guarantee an outcome. To work together successfully, we need some guidelines:

### 1. SCOPE OF PRACTICE/SERVICES:

Dr. Matthew Barnas is the Medical Director of Pelorus Elder & Behavioral Health, and is Board Certified in Geriatric and Adult Psychiatry. He assists individuals with issues like memory loss, anxiety, insomnia, depression, weight loss, ADD, paranoia, delusions, hallucinations, impulsivity, and dementia with behavioral disturbances. He has experience treating individuals in hospital-based, residential, and office-based settings. Dr. Barnas is also a certified [TMS](#) provider.

In addition, there are other excellent and highly-trained TMS professionals within the Pelorus TMS group including Psychiatrist Dr. Ritesh Amin and TMS Coordinator Kiaya DeLuca who will **also** be involved in providing care to you or your loved one. (The specifics will depend upon which of our two office locations at which you receive care). While Dr. Barnas will often personally conduct the first evaluation, the trained TMS Coordinator or another TMS trained team member will perform ongoing TMS treatments under the delegation of the attending physician.

For more information about our team of clinicians, please visit our website: <http://pelorustms.com/team/>

### 2. CANCELLATION AND NO SHOW POLICY:

As a Medicare-accepting and uniquely specialized TMS practice, we are very highly in-demand. Therefore, our available time for office consultations and TMS treatments are limited. If you have scheduled an appointment, please do try to keep it. If it's necessary to miss your appointment, we require advance notice, allowing us to assist someone else in need. **We require at least 24 business hours notice to cancel your appointment or TMS session.** If your appointment is on a Monday, we must be notified by the same hour on the preceding Friday.

If you do not give **at least 24 business hours** advance notice for a missed appointment, you (or your guardian) will be charged \$150 for a missed TMS consultation and/or \$250 for missed TMS treatments. Charges are based on appointment type. We will occasionally make an exception in extreme circumstances. If there was a charge made for a no-show or a missed appointment, we do expect you pay that fee in order to schedule a follow-up, as that is your responsibility, as insurance does not cover missed appointment.

14 Ridgedale Ave.  
Suite 103  
Cedar Knolls, NJ  
07927

P: 973- 295-6335  
F: 862-345-9037

All Correspondences

[www.pelorusTMS.com](http://www.pelorusTMS.com)

575 Route 28  
Building 2, Suite 2108  
Raritan, NJ  
08869

P: 908-722-4122  
F: 862-345-9037

### 3. COMMUNICATION:

Dr. Barnas and his staff can be reached at the central office number: 973-295-6335. The office team is staffed Monday through Friday from 9:00 AM to 5:00 PM. During business hours, if you are routed to our secure voicemail, it means our team is occupied assisting other patients, and you should kindly leave us a detailed message in order for us to follow up with you as efficiently as possible. Non-urgent calls are usually returned within the same day, but at the latest, by the end of the following business day.

After business hours, if you are calling with a non-urgent message, press “1” and leave your message. **Issues like “appointment questions” are not emergencies, and should be left in mailbox “1”.** The office is **not** staffed on weekends or holidays.

**If you are calling with a very serious, emergency situation, press “2” and leave your message there.** This emergency line is monitored 24 hours/day, 7 days/week. Your message will go directly to our provider that is on duty covering emergency calls.

**\*\*\*\*In the rare instance that you call us with an urgent emergency situation, and you do not receive a prompt return call, then IMMEDIATELY GO STRAIGHT TO THE NEAREST EMERGENCY ROOM, or CALL 911 for EMS ASSISTANCE. The ER staff will contact us, while you are safely under the hospital’s care and supervision.\*\*\*\***

### 4. EMAIL:

Be aware that email is not a confidential means of communication. We also cannot guarantee that email messages will be received or responded to in a timely fashion. As such, **email is not an appropriate way to communicate very urgent or confidential information.** Dr. Barnas and our medical providers do not email with patients or family, although our administrative office team will email with patients for non-urgent issues like appointment scheduling.

### 5. “PRIOR AUTHORIZATIONS” and “DEDUCTIBLES”:

**Some insurance policies may require a “Prior Authorization” before covering the costs of treatment. Or, your plan may involve a minimum “Deductible” payment every year.** You are responsible for learning about and understanding the particular details of your insurance policy. If your policy requires it, you must obtain “Prior Authorization” for your psychiatric treatment. You are also responsible to determine if you have any remaining “Deductible” on your policy (which would need to be paid by you, before your insurance policy would cover the cost of your treatment – exactly the same as an auto insurance policy “deductible”).

**When patients with a policy “deductible” are seen early in the year (ie January or February), they usually have to pay their deductible for that new year - therefore they receive a higher- than-normal bill. The reason for the higher bill is because your policy’s deductible has to be paid.** Please call your insurance company to clarify if your policy requires a “prior authorization” or has a “deductible” remaining. If your insurance denies coverage because of such, you are responsible for payment. **Every patient has a different policy with different details, so you must communicate directly with your insurers, to understand the particulars related to your own specific insurance policy.**

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**6. SECOND OPINION:**

If at any time you desire a second opinion (with an outside, non-Pelorus provider), please feel free to discuss this with us. We are eager to help you, and will not be offended by such a request.

**7. TMS:**

TMS may be recommended to help improve the symptoms which led you (or your loved one) to seek a consultation. If it is agreed that TMS is indicated, your treating clinician will discuss options that are available to treat your current condition. Information will be presented to you in language that you can understand.

**Treatment with TMS or medications of any kind always involves potential risks and benefits.** You will learn the expected benefits of TMS, absolute and relative contraindications, possible side effects and risks, its dosage and frequency.

By the end of the discussion you will have all the information you need to make an informed decision as to whether treatment is right for you (or your loved one). If you decide that the benefits of treatment outweigh the risks, treatment will be prescribed and initiated. **If you have questions about TMS, your treating Pelorus medical provider will be happy to answer them.**

**8. CONFIDENTIALITY:**

Confidentiality is the cornerstone of mental health treatment and is protected by the law. We can only release information about you to others with your written permission. Some basic information about diagnosis and treatment may be required as a condition of your insurance coverage.

Exceptions to confidentiality where disclosure is required by law:

- if there is threat of serious bodily harm to others, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization
- if there is threat to harm yourself, we are required to seek hospitalization for the patient, or to contact family members or others who can help provide protection
- if there is an indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, we must file a report with the appropriate state agency
- if you are involved in judicial proceedings, you have the right to seek to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require our testimony
- if due to mental illness, you are unable to meet your basic needs, such as clothing, food, and shelter, we may have to disclose information in order to access services to provide for your basic needs
- These situations have rarely arisen in our clinical practice, but should such situation occur, we will make every effort to fully discuss it with you before taking any action.

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**9. TREATMENT CONSENT:**

By signing below, you certify that you have read this four-page document and understand the terms stated in this Office Policy and Treatment Consent Form. You understand that you have the right to choose between treatment vs. non-treatment, and that you can always inquire about the risks and benefits of treatment options. You agree that Pelorus TMS will bill you for any missed appointments that were not canceled in advance, per policy number two on the first page. You indicate that you understand the nature of our offered services, the office and payment policies, insurance reimbursement, confidentiality issues, and our contact information, and that you agree to abide by the terms stated above during our professional relationship.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
**Patient**  
**(or Power-of-Attorney)**

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## Authorization to Release Health Information Pursuant to HIPAA

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

**Authorization:** By signing this form, I authorize:

- Any other providers involved in my medical care to release my records to Pelorus TMS.
- Pelorus TMS to release my records to the following people, without requiring a signed release from them:

Psychiatrist or Primary Care Provider: \_\_\_\_\_

Neurologist/ Other Doctors: \_\_\_\_\_

Therapist: \_\_\_\_\_

Family / Other (POA, Spouse, Parent, Children, etc): \_\_\_\_\_

I, or my authorized representative, request and authorize that health care information regarding my care and treatment be released as described below:

**Complete medical record** (unless otherwise noted here): \_\_\_\_\_

I *specifically authorize* the release of the following types of highly confidential information: AIDS or HIV, Mental Health Information, Treatment Recommendations, Drug and Alcohol information, and Sexually Transmitted Diseases. (Unless otherwise noted immediately above)

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Pelorus TMS.

I understand that signing this authorization is voluntary and that Pelorus TMS, may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal or state privacy regulations.

I have received a copy of this authorization.

**Purpose of Release:** Records are being released for **continuity of my medical care**, and/or for the reasons specified here: \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_  
(or Authorized Representative, i.e. Power of Attorney)

**Date:** \_\_\_\_\_

Name of Authorized Representative (if applicable) \_\_\_\_\_

Authority of Representative (ie Power of Attorney): \_\_\_\_\_  
(if applicable)

**Signature of Witness:** \_\_\_\_\_

Date \_\_\_\_\_ Referred by: \_\_\_\_\_

Patient: \_\_\_\_\_

Last Name

First Name

Middle Initial

Cell Ph:  \_\_\_\_\_ Home Ph:  \_\_\_\_\_ Email:  \_\_\_\_\_

(indicate preferred method of contact)

Sex:  M  F Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security # \_\_\_\_\_

Psychiatrist or Primary Care Provider: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Doc's Fax: \_\_\_\_\_ Doc's Address: \_\_\_\_\_

Neurologist: \_\_\_\_\_ Neurologist's Phone: \_\_\_\_\_

Neurologist Fax: \_\_\_\_\_ Neurol's Address: \_\_\_\_\_

Retired  Working  Student  On Disability Employer/School (if applies) \_\_\_\_\_

Spouse's Name (or Guardian/Next of Kin) \_\_\_\_\_

Who is responsible for this account? (i.e. Self, "Power of Attorney", etc.) \_\_\_\_\_

Relationship to patient: (if other than "Self") \_\_\_\_\_

Do you have Medical Insurance?  Yes  No If yes:

Name of **Primary** Insurance (i.e. Medicare, Cigna, etc.) \_\_\_\_\_

Name of **Secondary** Insurance (if any, i.e. AARP, etc.) \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone # \_\_\_\_\_

\*Credit Card # \_\_\_\_\_ Type (Visa/MC/Amex) \_\_\_\_\_ Exp. Date \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy Address \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with:

\_\_\_\_\_  
Name of Insurance Company

And assign directly to Pelorus TMS all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

\_\_\_\_\_  
Signature of Insured/Guardian

Date:

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Pelorus TMS for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

\_\_\_\_\_  
Signature of Insured/Guardian

Date:

\*In the event of late cancellation or no-show for a scheduled appointment, you may be charged a fee to your credit card



**NEW PATIENT INTAKE QUESTIONNAIRE**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

**Who referred you to Pelorus TMS, or how did you find out about this practice?**

\_\_\_\_\_

**Reason for seeking TMS treatment (i.e Diagnosis, Symptoms, Recent History)?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Stressors/Precipitants contributing to current situation/symptoms?**

\_\_\_\_\_  
\_\_\_\_\_

**Psychiatric Medications**

<b>Antidepressant Medications (Including current and past medications)</b>	<b>Dose</b>	<b>Schedule</b>	<b>Start Date</b>	<b>Stopped Date</b>	<b>Reason for Discontinuing Medication</b>
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					



**Past Psychiatric History?**

Current psychiatrists? \_\_\_\_\_

Current psychiatric diagnosis? \_\_\_\_\_

Current psychologist/therapist? \_\_\_\_\_

Type of Therapy? Individual      CBT      Group      IOP      Couple/Family

Start Date? \_\_\_\_\_      Frequency? \_\_\_\_\_

Any violent, self-injurious, or suicidal behaviors? \_\_\_\_\_

\_\_\_\_\_

Past treatment with TMS (“magnetic stimulation”) or ECT (“Shock Treatments”)?

\_\_\_\_\_

\_\_\_\_\_

**Substance Abuse History (i.e. Nicotine, alcohol, painkillers, illegal drugs, etc.)?**

Do you smoke? \_\_\_\_\_ If so, how many per day? \_\_\_\_\_

Have you ever smoked? \_\_\_\_\_ For how long? \_\_\_\_\_ How many per day? \_\_\_\_\_

Do you use or have you used any illegal drugs? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

\_\_\_\_\_

Have you misused, abused, or become addicted to any painkillers? \_\_\_\_\_

Do you consume alcohol? \_\_\_\_\_ If so, please describe the frequency and amount:

\_\_\_\_\_



**Past Medical History:**

	Yes	No		Yes	No
Vision Loss			Seizures with high fever as a child or baby		
Glaucoma			Head Trauma w/ Loss of Consciousness		
Loss of Hearing			Back pain		
Recurrent Vertigo			Hematological Disorder (Sickle Cell, Hemophilia)		
Hypertension (High Blood Pressure)			Bleeding Tendency		
Dyslipidemia (High Cholesterol)			Diabetes		
History of MI (“Heart Attack”)			Thyroid Disease		
COPD/Emphysema			Immunological Disorder (Rheumatoid Arthritis, Lupus, etc.)		
Gastrointestinal Disease			Chronic Allergies/Hay Fever		
Liver Disease			Depression		
Chronic Skin Condition			Psychiatric illness other than depression		
Osteoarthritis/ Degenerative Joint Disease			Kidney Disease, Prostate, or other urological disorder		
Chronic Sleep Disorder			Tuberculosis		
Stroke (CVA)			HIV or AIDS		
Alzheimer’s or Other Cognitive Disorder			Encephalitis or Meningitis		
Parkinson’s or Other Movement Disorder			Polio		
Essential Tremor			Infections (Lyme, Tuberculosis...)		
Fainting or Blackouts			Gynecological problems		
Seizures/Epilepsy			Any history of cancer		

**Please list any other medical illnesses not already described, or clarify any noted above:**

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**Other Current Medications (please list all medications, dose, and frequency/schedule for each):**

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**Allergies (medication and food related):**

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**Personal/ Social History**

Location born and raised? \_\_\_\_\_

Education/ Degree? \_\_\_\_\_

Occupation? \_\_\_\_\_

For how long? \_\_\_\_\_ If unemployed or retired, how long? \_\_\_\_\_

Marital Status? \_\_\_\_\_ Living situation? (alone, etc.) \_\_\_\_\_

Children? How many? \_\_\_\_\_

Any history of being the victim of abuse? \_\_\_\_\_

Any history of any legal problems, including DUI's? \_\_\_\_\_

Any family history of neurological or psychiatric illness? \_\_\_\_\_

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**REVIEW OF SYSTEMS:** PLEASE INDICATE ANY RELEVANT SYMPTOMS BELOW, OR CHECK "N/A" IF NO SYMPTOMS APPLY

	Other:	N/A
<b>CONSTITUTIONAL:</b> fever___ fatigue___ night sweats___ weight loss___		
<b>EYES:</b> glasses___ blindness___ double vision___ visual field deficit___ drooping eyelid___		
<b>EAR, NOSE, THROAT:</b> hearing loss___ tinnitus___ infection___ trouble swallowing___ snoring___		
<b>CARDIOVASCULAR:</b> shortness of breath___ chest pain___ edema___ palpitations___ heart murmur___		
<b>PULMONARY:</b> cough___ wheezing___ shortness of breath___ coughing up blood___		
<b>GASTROINTESTINAL:</b> constipation___ vomiting___ diarrhea___ rectal bleeding___ nausea___ abdominal pain___		
<b>SKIN:</b> rash___ itchiness___ ulcers___ lesions___		
<b>MUSCULOSKELETAL:</b> back pain___ joint pain/stiffness___ joint swelling___ muscle cramps or weakness___		
<b>NEUROLOGICAL:</b> memory loss___ headache___ tremor___ dizziness___ paralysis or weakness___		
<b>HEMATOLOGICAL/LYMPHATIC:</b> bleeding tendency___ tendency to bruise easily___ history of blood clots___		
<b>ENDOCRINE:</b> increased urination___ increased appetite___ intolerance to heat or cold___ weight loss___ weight gain___		
<b>ALLERGIC/IMMUNO:</b> swollen lymph nodes___ reactions to food or medications___		
<b>PSYCHIATRIC:</b> depression___ anxiety___ panic attacks___ insomnia___ hallucinations___ delusions___		
<b>UROLOGICAL:</b> incontinence___ nocturnal frequency___ burning on urination___ dialysis___ blood in urine___		
<b>INFECTIOUS DISEASE:</b> fever___ night sweats___ known disease___		
<b>OBGYN (women only):</b> pregnant___ painful menses___ abnormal menses___ vaginal discharge___ breast mass___		

**TMS ADULT SAFETY SCREEN (TASS) QUESTIONNAIRE**

1. Have you ever had an adverse reaction to TMS?

Yes\_\_\_ No\_\_\_

Comment:\_\_\_\_\_

\_\_\_\_\_

2. Have you ever had a seizure?

Yes\_\_\_ No\_\_\_

Comment:\_\_\_\_\_

\_\_\_\_\_

3. Have you ever had a stroke?

Yes\_\_\_ No\_\_\_

Comment:\_\_\_\_\_

\_\_\_\_\_

4. Have you ever had a head injury?

Yes\_\_\_ No\_\_\_

Comment:\_\_\_\_\_

\_\_\_\_\_

5. Do you have any metal in your head (outside of your mouth), such as shrapnel, surgical clips, or fragments from welding or metalwork?

Yes\_\_\_ No\_\_\_

Comment:\_\_\_\_\_

\_\_\_\_\_

6. Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intracardiac lines?

Yes\_\_\_ No\_\_\_

Comment:\_\_\_\_\_

\_\_\_\_\_

7. Do you suffer from frequent or severe headaches?

Yes\_\_\_ No\_\_\_

Comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Have you ever had any other brain-related condition?

Yes\_\_\_ No\_\_\_

Comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Have you ever had any illness that caused brain injury?

Yes\_\_\_ No\_\_\_

Comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Are you taking medication?

Yes\_\_\_ No\_\_\_

Comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. If you are a woman of childbearing age, are you sexually active, and if so, are you not using a reliable method of birth control?

Yes\_\_\_ No\_\_\_

Comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Does anyone in your family have epilepsy?

Yes\_\_\_ No\_\_\_

Comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**TMS Patient Screening Form**

**This section is to be filled out by the PATIENT/or patient representative. Please indicate if you have any of the following:**

Aneurysms clips or coils	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Wearable cardioverter defibrillator	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cardiac pacemaker or wires	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Implanted insulin pump	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Internal cardioverter defibrillator (ICD)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Programmable shunt or valve	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Carotid or cerebral stents	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hearing aid	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Deep brain stimulator	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Cervical fixation devices	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Metallic devices implanted in your head	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Surgical clips, staples, or sutures	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Dental implants	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	VeriChip microtransponder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cochlear implant/ear implant	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Wearable monitor (e.g. heart monitor)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
CSF (cerebrospinal fluid) shunt	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Bone growth stimulator	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Eye implants	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Wearable infusion pump	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cardiac stents, filters, or metallic valves	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Radioactive seeds	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Tattoo	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Portable glucose monitor	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Vagus nerve stimulator (VNS)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tracheostomy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Blood vessel coil	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Medical patch/nicotine patch	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Shrapnel, bullets, pellets, BBs, or other metal fragments	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other implanted metal or device If yes, please specify:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Age: \_\_\_\_\_ Weight (lbs): \_\_\_\_\_ Height: \_\_\_\_\_ Last Menstrual period: \_\_\_\_\_

Have you ever been a machinist, welder, or metal worker?  
 Have you ever had a facial injury from metal and/or metal removed from your eyes?  
 Are you pregnant?  
 Have you ever had a complication from an MRI?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Signature of person completing this form: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of TMS Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Patient ID # \_\_\_\_\_

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

add columns:

+  +

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)*

**TOTAL:**

**10.** If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

**Not difficult at all** \_\_\_\_\_

**Somewhat difficult** \_\_\_\_\_

**Very difficult** \_\_\_\_\_

**Extremely difficult** \_\_\_\_\_

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at [rls8@columbia.edu](mailto:rls8@columbia.edu). Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.