Providence HEALTH CARE

REQUEST FOR PERMANENT PACEMAKER IMPLANTATION

Phone: 604-806-9934 Fax: 604-806-8637

Date: _____

ALL REFERRALS are coordinated by the EP/Device Triage Coordinator: FAX to 604-806-8637.

Please include consult notes, ECGs, dictated history, laboratory results (within the last 6 weeks), and medication list.

Patient's name: (last, first) _____

Referring MD: _____ Family MD: _____

☐ **INPATIENT:** ***Does the patient require further testing/workup PRIOR to implant?*** ☐ No ☐ Yes - _____

Hospital: _____ Unit: _____ ☐ Phone: _____ Admission Date: _____

☐ **OUTPATIENT:** PHN: _____ DOB: _____

Address: _____ City: _____ Postal code: _____

Home telephone: _____ Work telephone: _____

URGENCY

☐ **FIRST AVAILABLE SURGEON or CARDIOLOGIST** *(rapid referral)*

☐ **SPECIFIC PHYSICIAN:** _____ *(Selecting specific physician could affect wait time)*

If device replacement is required for **"Battery End-of-Life"**, indicate **ABSOLUTE DEADLINE for scheduled replacement:** _____

☐ **Urgent inpatient** (within 24 hours) (temporary pacing or impending need for temporary pacing)

☐ **Semi-urgent** inpatient (Cannot go home before implant)

☐ **Urgent outpatient** (within 2 weeks) (Impending need for emergency admission)

☐ Semi-elective outpatient (2 to 4 weeks)

☐ Elective outpatient

PROCEDURE(s) REQUESTED: ☐ First implant ☐ Generator replacement ☐ Upgrade ☐ Right side ☐ Left side ☐ MRI compatible ☐ Pocket revision: (reason) _____

MAIN INDICATION: ☐ **AV Block:** ☐ 3rd degree ☐ 2nd degree ☐ 1st degree

☐ Sinus node dysfunction ☐ Vasovagal Syncope ☐ Bradycardia induced ventricular arrhythmia

☐ Pre-AVN Ablation ☐ Tachy-brady syndrome ☐ Carotid Hypersensitivity

☐ Atrial fibrillation with slow ventricular rate ☐ Falls Risk

☐ Syncope / Presyncope ☐ Exercise intolerance ☐ Inability to tolerate Beta/AVN blocker

CLINICAL STATUS Underlying atrial rhythm: Intrinsic rate:

☐ Sinus (including variants ☐ below 30 ☐ QRS duration: _____

☐ Atrial fibrillation/flutter ☐ 30 or above ☐ LBBB

☐ Unknown ☐ Other if above 120 mm: _____

Oral anticoagulation: ☐ Warfarin Most recent INR: _____ Date : _____

☐ Dabigatran ☐ Rivaroxaban ☐ Apixaban ☐ Anti-platelet: _____

☐ IV/SC anticoagulation (type): _____

☐ NYHA class ☐ Recent MI Date: _____

☐ LV Dysfunction (EF less than 40%) ☐ Channelopathy ☐ Mechanical Valve

☐ Family history of sudden cardiac death ☐ Hypertension ☐ History of CVA/TIA

☐ CHADS score: _____ ☐ Ischemic CMO ☐ Diabetes: ☐ Insulin ☐ Oral medications

RECOMMENDED DEVICE:

☐ AAI ☐ VVI ☐ DDD ☐ Loop recorder ☐ Biventricular ☐ Other: _____

Vendor preference and reason: _____ Model: _____

FOLLOW-UP APPOINTMENT (Arrange follow-up appointment when booking implant procedure)

WHERE WILL THIS PATIENT BE FOLLOWED POST-IMPLANT?

☐ **SPH Device Clinic:** ☐ First available physician ☐ Specific physician: _____ ☐ **Other:** _____

Follow-up appointment: _____ (date/time) Clinic location: _____

Physician name: _____ **Signature:** _____