Providence HEALTH CARE

REQUEST FOR IMPLANTABLE CARDIOVERTER DEFIBRILLATOR

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 Date of last implant: _____

☐ Lead revision/replacement ☐ Upgrade ☐ Pocket revision (reason): _____

☐ Right side ☐ Left side ☐ Other: _____

MAIN INDICATION: ☐ Primary prevention ☐ Secondary prevention

☐ Cardiac arrest-VF ☐ Cardiac arrest-VT ☐ Cardiac arrest-unknown

☐ Syncope with high risk characteristics ☐ Syncope with inducible VF/VT

☐ Sustained VT ☐ Other: _____

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

DEFIBRILLATION THRESHOLD TESTING: (MUST BE Indicated) ☐ Yes ☐ No ☐ Implant physician discretion

RECOMMENDED DEVICE: ☐ VVI ☐ DDD ☐ Biventricular

Vendor preference and reason: _____

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 ☐ **Other:** _____

☐ Specific physician: _____

Follow-up appointment: _____ Clinic location: _____

date/time

Physician name: _____ **Signature:** _____