UNIVERSITY OF OTTAWA HEART INSTITUTE
INSTITUT DE CARDIOLOGIE DE L'UNIVERSITÉ D'OTTAWA

PACEMAKER / ICD REGISTRY

❑ **Outpatient Referral to be faxed to 613-696-7123**

❑ **Inpatient Referral to be faxed to 613-696-7144**

Unique number _____

Name _____
SURNAME *FIRST NAME* *INITIAL*

❑ Male ❑ Female DOB _____/____/____ Age _____

Ontario Health # _____

OR ❑ Other Province ❑ Other Country ❑ Not Available

Address _____

Postal Code Phone

Referring MD: _____ Date of Referral: _____ /yy ____ /mm ____ /dd

Location: ❑ Home ❑ UOH ❑ Other: _____

Referring Physician Details: ❑ Internist ❑ EP Cardiologist ❑ General Cardiologist ❑ Family/GP ❑ Cardiovascular Surgeon

REFERRING PHYSICIAN TO COMPLETE

REASON(S) FOR REFERRAL

ICD ❑ ICD Primary Prevention ❑ ICD Secondary Prevention
❑ CRT-ICD Primary Prevention ❑ CRT-ICD Secondary Prevention
❑ Pacemaker ❑ Reveal

CLINICAL HISTORY/PHYSICAL EXAM

Patient History:

❑ Ischemic CM ❑ Non-Ischemic CM
❑ Hypertrophic CM ❑ Infiltrative CM
❑ Long QT syndrome ❑ ARVC
❑ Brugada ❑ Valvular Heart Disease
❑ Congestive Heart Disease ❑ No Structural Heart Disease
❑ Inherited Arrhythmia Syndrome ❑ Cardiac Arrest ❑ No ❑ Yes
❑ Other: _____

Is the patient competent to consent? ❑ No ❑ Yes
Is patient on coumadin? ❑ No ❑ Yes
Does the patient have a physical or mental condition making it difficult to lie flat for more than 3 hours with minimal sedation? ❑ No ❑ Yes
Current Device ❑ No ❑ Yes
Current Device Details:

HEART FAILURE CLASS NYHA ❑ 1 ❑ 2 ❑ 3 ❑ 4

LV function ❑ Done ❑ Not done
Method: ❑ Echo ❑ MUGA
Actual EF_____ enter number 0% to 70%
EF Grade: ❑ I greater than 50% ❑ II 35-43 %
❑ III 20-34 % ❑ IV less than 20 % ❑ N/A

DOCUMENTED ARRHYTHMIA

❑ No ❑ Yes, If yes please provide sample rhythm strip/ECG
❑ VF ❑ VT ❑ SVT ❑ Syncope ❑ Other: _____
❑ 2^0 ❑ 3^0 ❑ Pauses
❑ SSS ❑ SSS + AV block ❑ Other: _____

COMORBIDITY ASSESSMENT

NYHA ❑ 1 ❑ 2 ❑ 3 ❑ 4 Height _____ cm Weight: _____ kg

	No	Yes	
Creatinine _____			Date _____ yy ____ mm
Dye Allergy	❑	❑	
Latex Allergy	❑	❑	
Dialysis	❑	❑	
Diabetes	❑	❑	❑ Insulin ❑ Oral Meds
Previous CABG	❑	❑	Date _____ yy ____ mm
Previous PCI	❑	❑	Date _____ yy ____ mm
Hypertension	❑	❑	
COPD	❑	❑	
Congestive Heart Failure	❑	❑	
Valvular Disease	❑	❑	
Anticoagulant:	❑	❑	Specify _____
Vascular Disease History	❑	❑	CAD, PVD or other atherosclerosis
Prior stroke/TIA/Thromboembolism	❑	❑	
Recent MI	❑	❑	Date _____ yy ____ mm

History of MI in months ❑ Unknown
❑ 1-3 ❑ more than 3-6 ❑ more than 6-12 ❑ more than 12

Referral Physician signature: **Date (yyyy/mm/dd):**

Legend:

ARVC	Arrhythmogenic right ventricular cardiomyopathy	CABG	Coronary artery bypass graft	CAD	Coronary artery disease	CM	Cardiomyopathy
COPD	Chronic obstructive pulmonary disease	CRT	Cardiac resynchronization therapy	MI	Myocardial infarction	EF	Ejection fraction
ICD	Internal cardiac defibrillator	PCI	Percutaneous coronary intervention	VT	Ventricular tachycardia	AV	Atrial ventricular
PVD	Peripheral vascular disease	SVT	Supraventricular tachycardia	SSS	Sick sinus syndrome	VF	Ventricular fibrillation
VVI	Pacing in ventricle, sensing in ventricle, inhibiting intrinsic action in ventricle			TIA	Transient ischemic attack		
DDD	Dual pacing in atria-ventricular, dual sensing in the atria-ventricular, dual inhibiting and triggering in atria-ventricular						

Patient: Chart no.:

PACEMAKER / ICD BOOKING SHEET

Section A- ICD Rounds

Date of ICD Rounds: _____

ICD Rounds Decision:

❑ Yes and patient agreed to ICD ❑ No Patient does not meet criteria but further testing or treatment needed and patient will be re-presented at a later time

❑ Yes and patient declined ICD ❑ No Patient does not meet criteria at the current time and sent back to referring physician

Physicians present at ICD rounds: ❑ Birnie ❑ Davis ❑ Sadek ❑ Green ❑ Lemery ❑ Nair ❑ Nery ❑ Redpath

Section B - Device Prescription

Is the pulse generator sub-pectoral? ❑ Yes ❑ No

❑ ICD	❑ Lead	❑ Pacemaker	❑ Reveal
❑ VVI (R) (L)	❑ RA+RV+LV	❑ VVI (R) (L)	❑ Implant
❑ DDD (R) (L)	❑ RV+LV	❑ DDD (R) (L)	❑ Explant
❑ CRT (R) (L)		❑ CRT (R) (L)	

Company: ❑ Medtronic ❑ Boston Scientific ❑ Eiher ❑ Other

DFT testing: ❑ Not to be done ❑ Must be done

Any specific Programming instructions:

Section C - Anesthesiology Requirements

Anesthesia care required ❑ Yes ❑ No

Section D - Medication Orders

Coumadin Instructions: ❑ Stop 4 days before -no substitution required

❑ Continue Coumadin and do procedure with therapeutic INR

❑ Check INR pre-procedure: ❑ 4 days ❑ 1 day

Other Anti-coagulant Instructions:

Physician Signature for medication orders: **Date** (yyyy/mm/dd):

Section E- EP Physician to do Procedure:

Supported with: _____

❑ Birnie ❑ Davis ❑ Sadek ❑ Green ❑ Lemery ❑ Nair ❑ Nery ❑ Redpath ❑ Any

EP Physician Estimation of Urgency:

❑ Urgent inpatient: 24-48 hours ❑ Semi-Urgent (_____ weeks) ❑ Priority (15-60 days) ❑ Elective / Routine

EP Physician Signature: **Date** (yyyy/mm/dd):

EP PHYSICIAN TO COMPLETE

WAIT LIST TO COMPLETE

Date Booked: _____ yy____ /mm ____ /dd Procedure MD: _____

Patient Letter / Brochure Sent: _____ yy____ /mm ____ /dd

Admit Date: _____ yy____ /mm ____ /dd ❑ Admit ❑ DU ❑ PAU ❑ PAU w/ GA ❑ PAU w/ BHcg

Procedure Date: _____ yy____ /mm ____ /dd

Translator Required: ❑ N ❑ Y Specify: _____

Comments: