ISLAND HOSPITAL SURGICAL SERVICES

360-299-1314 or 360-299-4272

REQUEST FOR PACEMAKER/ICD PRE/INTRA-OPERATIVE INFORMATION
PLEASE HAND DELIVER TO A DEVICE TECHNICIAN

Pre-Operative Device Form

Patient _____ DOB: _____

Scheduled for surgery on _____ with Dr. _____

Surgery/Procedure _____

Procedure length _____

Electrocautery may be used

PLEASE COMPLETE BOTTOM PORTION AND FAX TO: 360-299-1359

Cardiologist: _____ Phone: _____

Pacemaker or ICD MODEL _____ # _____ SERIAL# _____

Baseline Programming _____ Base Rate _____

Underlying Rhythm _____ Date Placed: _____

Indication for Device: _____

Magnet Anticipated Response: Mode _____ Rate _____

DATE OF LAST PACEMAKER INTERROGATION: _____

Perioperative Recommendations:

_____ Pacemaker Rep _____ is required for pacemaker reprogramming the day of surgery. Call to Schedule and Fax this form to: Rep Name: _____ Phone # _____ Fax # _____

_____ Patient is pacemaker dependent and will require continuous monitoring.

_____ If defibrillator is off, the patient needs continuous monitoring.

Additional Information:

_____

_____

_____

MD Signature: _____ Date/Time: _____

Patient ID Sticker