Providence HEALTH CARE

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

REQUEST FOR IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (ICD)

Date: ________________________________

Send ALL relevant documentation with this request *(e.g. consult notes, lab results, ECG, Holter monitor, and/or echo)*

SPH BOOKING OFFICE:	**VGH BOOKING OFFICE:**
FAX: 604-675-2643 Phone: 604-806-9934	**FAX: 604-875-5142** Phone: 604-875-4111 (local 61185)

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: ____________ Email: ____________

URGENCY

☐ **FIRST AVAILABLE OPERATOR**
(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 ☐ Subcutaneous ☐ Sub muscular ☐ Other: ____________

MAIN INDICATION:

☐ Primary prevention ☐ Cardiac arrest-VF ☐ Syncope with high risk characteristics

☐ Secondary prevention ☐ Cardiac arrest-VT ☐ Syncope with inducible VF/VT

NYHA class: ________ ☐ Cardiac arrest-unknown ☐ Sustained VT ☐ Other: ____________

CLINICAL STATUS:

Underlying atrial rhythm:

☐ Sinus (including variants

☐ Atrial fibrillation/flutter

☐ CHADS score: ________

Intrinsic rate:

☐ below 30

☐ 30 or above

☐ Unknown

☐ QRS duration: ____________

☐ LBBB

☐ Other if above 120 mm: ____________

Oral anticoagulation: ☐ Warfarin Most recent INR: ________ Date : ____________

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

☐ IV/SC anticoagulation (type): ____________________

LV Assessment type (echo, MUGA/MIBI, Angiogram , MRI) EF: _____% Date: ________ ☐ Recent MI Date: ________

☐ Channelopathy ☐ Mechanical valve

☐ Family history of sudden cardiac death ☐ Hypertension

☐ Ischemic CMO ☐ Diabetes: ☐ Insulin ☐ Oral medications

☐ History of CVA/TIA ☐ Other: ____________________

____

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

RECOMMENDED DEVICE: ☐ VVI ☐ DDD ☐ Biventricular Vendor preference & reason: ____________

FOLLOW-UP APPOINTMENT

Device Clinic: ____________________ ☐ First available physician

____________________ ☐ Specific physician: ____________

Physician name: ____________________ **Signature:** ____________________