# REQUEST FOR PERMANENT PACEMAKER IMPLANTATION

**Date:** _____

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

**SPH BOOKING OFFICE:**
**FAX: 604-675-2643** Phone: 604-806-9934

**VGH BOOKING OFFICE:**
**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 Current device: _____ ☐ 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
☐ Pre-AVN Ablation
☐ Atrial fibrillation with slow ventricular rate
☐ Syncope / Presyncope

☐ Vasovagal Syncope
☐ Tachy-brady syndrome
☐ Exercise intolerance

☐ Bradycardia induced ventricular arrhythmia
☐ Carotid Hypersensitivity
☐ Inability to tolerate AVN blocker
NYHA class: _____

**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
- ☐ Family history of sudden cardiac death
- ☐ Ischemic CMO
- ☐ History of CVA/TIA
- ☐ Mechanical valve
- ☐ Hypertension
- ☐ Diabetes: ☐ Insulin ☐ Oral medications
- ☐ Other: _____

**RECOMMENDED DEVICE:**

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

Vendor preference and reason: _____ Model: _____

## FOLLOW-UP APPOINTMENT

**Device Clinic:** _____

_____

☐ First available physician

☐ Specific physician: _____

**Physician name:** _____ **Signature:** _____