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:** _____