Patient Label

SIBLEY MEMORIAL HOSPITAL
PACEMAKER/ICD PREOPERATIVE INFORMATION SHEET

Date: Time:

Patient Name:

Date of Anticipated Surgery: *(please note: failure to complete form may delay surgery)*

Patient Date of Birth:

Surgeon Name:

Cardiologist Name:

Cardiologist (Name/Number) for Postoperative Management:

DEVICE DATA

☐ Pacemaker
☐ ICD

Manufacturer:

Model:

ID Number:

Indication for device implantation:

Is patient pacemaker dependent?
☐ Yes ☐ No

Mode:
Lower rate:
Upper rate:

Magnet Deactivation/Reactivation Function Active
☐ Yes ☐ No

PERIOPERATIVE MANAGEMENT

Reprogram Preoperatively
☐ Yes ☐ No ☐ None needed

Magnet may be placed in the Operating Room
☐ Yes ☐ No

Note: If the device is reprogrammed or deactivated during the perioperative period, the patient must remain in a monitored setting until discharged by a cardiologist.

_____
CARDIOLOGIST SIGNATURE /NUMBER

FAX FORM TO ATC NO LATER THAN 48 HOURS PRIOR TO SURGERY (202-364-7639)