Request for Outpatient Preoperative Pacemaker/Defibrillator Information

Dr. ___________________________  Date of Request: ________________  (Cardiologist)

You or your practice have been identified as managing this patient's implanted cardiac rhythm management device. Please complete the appropriate section of this form to assist in preparation of the proposed surgery.

Preoperative cardiac evaluation may have been requested from the primary cardiologist.

To be completed by PAT Clinic Staff:

**Procedure:**

**Date of Procedure:** __________________

**Location:**

- [ ] WakeMed Raleigh
- [ ] WakeMed Cary
- [ ] WakeMed North

**Planned Postoperative Disposition:**

- [ ] Outpatient
- [ ] Observation
- [ ] Inpatient
  - What is the expected LOS? ___________________
  - What are the clinical reasons? ___________________

To be completed by Cardiologist:

- [ ] Pacemaker
- [ ] Defibrillator (ICD)

**Manufacturer:** ______________________  **Model:** ____________________

**Indications for Implantation:** ___________________________________________________________________

**Date of last device interrogation:** __________________

**Device Location:**

- [ ] L. Chest
- [ ] R. Chest
- [ ] Other: ___________________________

Is patient pacemaker dependent?  [ ] Yes  [ ] No

**Underlying rhythm:** ___________________________

For Pacemakers:

Will magnet application temporarily convert device to an asynchronous pacing mode?  [ ] Yes  [ ] No

If magnet is used, does patient need to follow up with cardiologist as an outpatient?**  [ ] Yes  [ ] No

For Defibrillators (ICDs):

Will magnet application temporarily disable anti-tachycardia therapies?  [ ] Yes  [ ] No

Will magnet application permanently change any device settings?  [ ] Yes  [ ] No

If magnet is used, does patient need to follow up with cardiologist as an outpatient?**  [ ] Yes  [ ] No

**Additional information or recommendations:** _________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**Cardiologist/PA/NP Signature:** ___________________________  **Telephone/Pager #:** ________________

**Date:** ________________  **Time:** ________________

Fax this form and any associated documentation to:

- WakeMed at Raleigh Pre-Op Clinic (919) 350-7554
- WakeMed Cary Pre-Op Clinic (919) 350-2285
- WakeMed North Pre-Op Clinic (919) 350-6892