



ISLAND HOSPITAL SURGICAL SERVICES

360-299-1314 or 360-299-4272

REQUEST FOR PACEMAKER/ICD PRE/INTRA-OPERATIVE INFORMATION PLEASE HAND DELIVER TO A DEVICE TECHNICIAN

Pre-Operative Device Form

Patient _____ DOB: _____

Scheduled for surgery on _____ with Dr. _____

Surgery/Procedure _____

Procedure length _____

Electrocautery may be used Monopolar Bipolar

PLEASE COMPLETE BOTTOM PORTION AND FAX TO: 360-299-1359

Cardiologist: _____ Phone: _____

Pacemaker or ICD MODEL _____ # _____ SERIAL# _____

Baseline Programming _____ Base Rate _____

Underlying Rhythm _____ Date Placed: _____

Indication for Device: _____

Magnet Anticipated Response: Mode _____ Rate _____

DATE OF LAST PACEMAKER INTERROGATION: _____

Perioperative Recommendations:

_____ Pacemaker Rep _____ is required for pacemaker reprogramming the day of surgery. Call to Schedule and Fax this form to:
Rep Name: _____ Phone # _____ Fax # _____

_____ Patient is pacemaker dependent and will require continuous monitoring.

_____ If defibrillator is off, the patient needs continuous monitoring.

Additional Information:

MD Signature: _____ Date/Time: _____

Title:	Pre-Operative Pacemaker / Implantable Cardioverter Defibrillator Form	Version Effective Date:	08/25/2022
Document Owner:	Surgical Services	Page	1 of 1
<i>Printed copies are for reference only. Please refer to the electronic copy for the latest version</i>			