



# 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: \_\_\_\_\_

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