McLaren PORT HURON

Patient Identification

PACEMAKER INDICATION FORM
(For Initial Implants or Generator Replacements)

INSTRUCTIONS: Review and complete all section(s). **Must** be completed for **initial implants** and **generator replacements** prior to the initiation of the procedure.

Patient Name: _____

A. Indication(s) for cardiac pacemaker Implant or Replacement:

(**Check all that apply**)

[ ] Patient qualifies for cardiac resynchronization therapy
[ ] Generator replacement is indicated
[ ] Third degree (complete) atrioventricular (AV) block
[ ] Second degree atrioventricular (AV) block, Mobitz type I or II
[ ] Sinoatrial node dysfunction
[ ] Sick sinus syndrome/ Tachycardia-bradycardia syndrome
[ ] Congenital heart block
[ ] Congenital heart disease
[ ] Obstructive hypertrophic cardiomyopathy
[ ] Sustained pause-dependent ventricular tachycardia, with or without QT prolongation
[ ] Pacemaker insertion in advance of AV node ablation procedure
[ ] Other cause of non-reversible symptomatic bradycardia, specify: _____
_____
_____

B. Patient has the following symptoms attributed to bradycardia/arrhythmia:
(Check all that apply)

[ ] Dizziness [ ] Lightheadedness [ ] Syncope/near-syncope [ ] Heart failure
[ ] Exercise intolerance caused by poor heart rate response to exertion [ ] Seizure [ ] Confusion
[ ] Other _____

C. Check one of the following:

[ ] Patient's bradycardia, tachycardia-bradycardia syndrome, or sustained pause-dependent ventricular tachycardia does not have a temporary or reversible cause;

OR

[ ] Patient receives necessary medical therapy that contributes to bradycardia that cannot be safely reduced or withdrawn due to the underlying condition of: _____
_____

Provider Signature: _____ Date:_____ Time:_____

Cath Lab Reviewer Signature: _____ Date:_____ Time:_____

Scheduled Procedure Date: _____