McLaren
GREATER LANSING

Managing Cardiovascular Implantable Electrical Devices (CIED)
Preoperative Inquiry of Device

1. ***Type of Device***
   ____ Pacemaker
   ____ Implantable Cardiac Defibrillator [ICD] *or* Cardiac Resynchronization [CRT]

2. ***Date of last device interrogation:*** _____ ICDs or CRTs < 6 months and pacemaker < 12 months

3. ***Manufacturer and Model #:*** _____

4. ***Implant Date:*** _____

5. ***Indication for Device Placement***
   ____ Pacemaker – Sick Sinus Syndrome, AV Block, Syncope, _____
   ____ ICD – Primary [anti-tachyarrhythmia] or Secondary Prevention/Cardiac Resynchronization Therapy

6. ***Battery Life:*** Documented as > 3 months
   ____ Yes
   ____ No

7. ***Programming:*** Pacing Mode and Programmed Rate _____

8. ***Is the patient pacemaker dependent?***
   ____ Yes – What is the underlying rhythm and rate, if it can be determined _____
   ____ No

9. ***Is there any known recall/alert status on leads and/or generator?***
   ____ Yes
   ____ No

(MGL documentation only)

10. ***CIED Clinic or Cardiologist contacted via phone/fax for above device information***
    ****(NOTE: If preoperative device inquiry form is faxed – return of info is required within 24 hrs)***

    ____ Yes Date _____ Time _____ Signature _____
    ____ No

11. ***Anesthesia provider contacted:*** Name _____

    ____ Yes Date _____ Time _____ Signature _____
    ____ No

12. ***Device Representative needed/contacted?***

    ____ Yes Date _____ Time _____ Signature _____
    ____ No

    Name of Device Rep contacted: _____

    ____ N/A Comments: _____