



56591



ICD Implantation

Fax to: (206) 685-7569
or (800) 253-6404

Complete this form for each attempted or successful implantation, lead repositioning, lead replacement, or ICD explantation. Complete a separate form for each attempt.

____ - ____ - ____

Affix Patient ID # Here **seqnum10**

1 Date of Implantation: **days10**

____ / ____ / ____
Month Day Year

tmproc10

Time procedure began:
(24 hour clock)

____ : ____

2 Is this procedure (check all applicable):

- origim10** Original generator & lead implantation
- gnonly10** Original generator-only implantation
- ldonly10** Original lead-only implantation
- ldrepo10** Lead repositioning (Skip items 5 and 9)
- gnrepl10** Generator replacement
- ldrepl10** Lead replacement
- explnt10** Explantation, no replacement (Skip items 5, 10, 11, and 12)
- noimpl10** No implantation will be attempted (Complete item 12 only)

Complete a Lead and Generator Identification form for any leads/generator implanted, explanted, or repositioned. Complete ICD Complications form 30 days after implant and ICD Evaluation form at hospital discharge.

Important:

If this replacement is due to a generator or lead system failure other than normal battery depletion, notify the CTC immediately by FAX and verbally by telephone call. Notification should be made immediately, but in any case, is required within 10 working days of discovery of the malfunction.

If replacement or explantation, which components were replaced or explanted?

gnrep210 Generator. If yes, specify reason:

0 Battery replacement for end of life (does NOT require special notification to CTC).

genbat10

Months in use:

____ **batmon10**

1 Other, specify:

ldrep210 Lead replacement/repositioning. If yes, specify reason:

0 Dislodgement (does NOT require special notification to CTC)

lead10

1 Other, specify:



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IMPLANT

Date of implantation:

		/			/				
Month			Day			Year			

		-				-					
Affix Patient ID # Here											

3 Location of procedure (check one): OR Cath/EP lab
 1 2

4 Participating physicians (check one on each applicable line):

	Primarily Electrophysioloast 1	Primarily Suraeon 2	Combined Eaual Effort 3	Other 4	Not done 0
oplead10 Leads:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
oppock10 Pocket:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
opep10 EP/Device Testing:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5 Route of implantation: 1 NTL 2 Median sternotomy 3 Thoracotomy
 4 Subcostal 5 Subxiphoid 6 Thoracoscopy

For NTL, route of insertion: 1 Subclavian
 2 Cephalic
 3 Other:

Location of generator: 1 Abdominal
 2 Pectoral
 3 Other:

6 Duration of procedure:

 :

 ("skin-to-skin" time)
 tmdur10 hours minutes

7 Anesthesia:

Anesthesia type (check one):
 1 General with intubation
 2 General without intubation
 3 Conscious sedation

anpres10 Anesthesiologist/Anesthetist present? Yes No
 1 0

8 Use of antibiotics (check all that apply): Pre-op **abpre10** Intra-op **abintr10** Post-op **abpost10** Not used **abnone10**

9 Irrigation of pocket with antibiotics? Yes No
 1 0 **irrab10**

