



DEPARTMENT OF ANESTHESIA
 CARDIAC RHYTHM MANAGEMENT DEVICES (CRMD)
 PRE-OPERATIVE EVALUATION AND INFORMATION FORM



Continuum Health Partners, Inc.

Completed by Surgeon	Patient Name:	DOB:
	Requesting Physician:	FAX No:
	Cardiologist:	
	Date of Surgery:	
	Surgical Procedure:	
	Type of anesthesia: General / Mac / Local	
	Will electrocautery be used? Yes / No	If yes: Mono / Bipolar

Completed by Cardiology	Dear Doctor: The patient named above has identified you as the physician providing management of his/her CRMD. The patient is scheduled to undergo the surgery listed above; in order to provide safe peri-operative care to this patient you are being asked to provide information relating to this patient's CRMD. Please complete this form promptly and fax to both the surgeon's office and the NYEE Anesthesia Department (212-614-8233) .
	Device Information: (Please attach copy of CRMD card as necessary)
	Type of Device: ICD versus Combination Device (pacemaker/ICD)
	Device Name/Model/serial#:
	Date of implantation:
	Clinical indication for device: (if CHF, LVEF)
	Product Recalls/Warnings:
	Date of last interrogation/device evaluation? (within last 4 months):
	Device battery status?
	Last anti-tachycardia therapy delivered?
	Device response to magnet therapy?
	Is the patient pacemaker dependent? yes/no
	Does the patient require additional pre-operative evaluation/testing?
	Additional Recommendations:

Cardiologist Signature:	
Date:	Contact Number: