CARDIAC IMPLANTABLE ELECTRICAL DEVICE (CIED) PRE-OPERATIVE CONSULT REQUEST FROM OPERATIVE TEAM TO CIED PHYSICIAN

Scheduled Procedure: __________________________ Date of Surgery: __________

Anatomic location of surgical procedure: __________________________

Patient position during the procedure: __________________________

Monopolar electrosurgery: ☐ Yes ☐ No

Other sources of electromagnetic interference: ☐ Yes ☐ No

Cardioversion or defibrillation anticipated: ☐ Yes ☐ No

Surgical venue: ☐ Surgical suite ☐ Procedural suite ☐ Other: __________________________

Anticipated post procedural arrangements:
☐ Discharge to home in less than 23 hours ☐ CCU ☐ Telemetry ☐ Other: __________________________

Unusual circumstances:
☐ Anticipated large blood loss ☐ Operation in close proximity to CIED

☐ Surgical procedure that could impair/damage or encroach upon CIED leads

☐ Other: __________________________

Manufacturer and model of CIED: __________________________

☐ PM ☐ ICD

MD/PA/NP signature __________________________ ID# __________ Date __________ Time __________