PACEMAKER/ICD PRE-OP PROCEDURE ORDERS

SECTION 1: PROCEDURALIST/PRE-OP LIP <u>must</u> complete STEPS 1 & 2

SECTION 2: Steps 3 [Cardiologist] & 4 [Proceduralist/LIP or representative] are completed **<u>only if</u>** reprogramming is required

Consider PASC referral for all patients with Pacemaker/ICD

STEP 1: <u>PROCEDURALIST/PRE-OP LIP</u> <u>MUST</u> Complete pacemaker/ICD assessment criteria **PRE-OP.**

1. Define the type of device brand and type:
   a. Circle *ONE*: Medtronic / Boston Scientific / St. Jude / Biotronik
   b. Pacemaker / ICD
2. Pacemaker Dependent? ☐ NO ☐ YES

   (Pacemaker dependency is assumed if there are pacemaker spikes in front of all or most P waves and/or QRS complexes based on 12 lead EKG evaluation)

3. Managing Cardiologist/EP: _____

   If the patient does not have an assigned Cardiologist/EP, contact the No-Doc Cardiologist on call **only if reprogramming is needed.**

STEP 2: <u>PROCEDURALIST/PRE-OP LIP</u> <u>MUST</u> Complete surgery/procedure criteria **PRE-OP**

☐ Cardiac Surgery ☐ Surgery within 6-12" of pacemaker/ICD ☐ Surgery to head/neck, abdomen (above the umbilicus), upper limb (proximal to elbow), or chest in pacemaker dependent patient
☐ Prone position

If the patient does not meet any of the above surgery/procedure criteria, the patient does not require pacemaker/ICD reprogramming. *Choose NO.*

☐ **NO, reprogramming is not required.** Have a magnet available and monitor during surgery to ensure no inhibition of the pacemaker/ICD.

If NO, no further orders are required.

If the patient meets any of the above surgery/procedure criteria, the patient does require pacemaker/ICD reprogramming. *Choose YES.*

☐ **YES, reprogramming is required.** Fax order form to managing Cardiologist/EP.

- Providence Medical Group Fax: 425-259-8600
- Western Washington Medical Group Fax: 425-225-2790
- Everett Clinic Fax: 425-339-5448
- Other:_____

Proceduralist/Pre-OP LIP FAX #: _____ **(orders will be returned to this FAX #)**

Proceduralist/Pre-OP LIP Signature: _____ **ID #** _____ **Date/Time** _____

SECTION 2: DEVICE REPROGRAMMING ORDERS (<u>PRN</u>)

STEP 3: <u>CARDIOLOGIST/EP</u> <u>MUST</u> complete device reprogramming orders.

☐ Pre-OP: Reprogram device to: Mode_____ Rate_____
☐ ICDs Only: Tachyarrhythmia therapies ☐ ON ☐ OFF
☐ Post-Op/Procedure: Reprogram back to original setting prior to discharge

| **Return orders to LIP fax # noted above** |

Cardiologist/EP LIP Signature: _____ ID # _____ Date/Time_____

STEP 4: PROCEDURALIST/PRE-OP LIP *(or designated representative)* <u>MUST</u> contact device representative if reprogramming needed

Device Representative Notified: _____ Date/Time_____

☐ Biotronik (800) 547-0394 ☐ Boston Scientific (800) 227-3422 ☐ Medtronic (800) 678-2500 ☐ St. Jude (800) 722-3423

Proceduralist/pre-op LIP, or Representative:
Signature: _____ Date/Time_____

PLACE PATIENT LABEL HERE

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Patient Name:_____

Birthdate: _____