(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PREOPERATIVE CARDIAC DEVICE EVALUATION

Version 1 Approved 8/22/19

Please complete this form for all patients that have a cardiac implanted electronic device (pacemaker/ICD) and it is anticipated that ELECTROCAUTERY or RADIOFREQUENCY may be required during their procedure.

This section is completed by:
-Primary nurse for all inpatients
-Pre-admit/scheduler for all outpatients

PATIENT'S PRIMARY CARDIOLOGIST: Dr. _____

TREATING SURGEON: Dr. _____

(Mr. / Ms.) _____DOB:_____ is scheduled for _____ (procedure).

Surgery Date:_____ Time if known:_____
Facility Site:_____

This section is completed by:
-Cardiologist on-call for afterhours procedures
-Benefis Cardiac Rhythm Management RN for all other occurrence

Device Information

1. **Type of device** - ☐ PACEMAKER ☐ DEFIBRILATOR
2. **Brand and model** – ☐ Boston Scientific :_____ ☐ Medtronic:_____
   ☐ St. Jude Medical:_____ ☐ Biotronik:_____ ☐ Sorin/ELA:_____
3. **Current mode and lower rate limit** - _____
4. **Is the patient pacemaker dependent?** - YES NO
5. **Would you suggest applying a magnet during cautery and/or radiofrequency?** - YES NO
6. **How will the device respond to a magnet?** – Please mark as applicable.
   a. _____ ICD THERAPIES ARE DISABLED
   b. _____ PACE ASYNCHRONOUS AT:_____ BPM
   c. _____ OTHER: _____
7. **Would you suggest manually reprogramming the device prior to procedure?** - YES NO
   If yes, how? - ☐VOO: _____ bpm ☐ DOO:_____ bpm ☐Other:_____
8. **Any other suggestions**: _____
   _____

PLEASE FAX COMPLETED ORDER TO BENEFIS CARDIAC RHYTHM MANAGEMENT CLINIC AT 406-731-8584. FOR ANY QUESTIONS PLEASE CALL US AT 406-731-8525.

Provider Signature:_____Date:_____Time:_____