New York Eye and Ear Infirmary of Mount Sinai

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

Reset this Form

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:

Web Form