

Referral Form For ICD Implantation

Name: _____

MRN # _____ DOB: _____

1) Ejection Fraction _____ Date of last Echocardiogram _____

2) LV Thrombus? YES NO

3) Type of cardiomyopathy _____

4) Non-ischemic dilated cardiomyopathy > 9months? YES NO N/A

5) NYHA class _____

6) QRS duration _____ PR interval _____

7) Documented V-Tach/V fib or Long QT syndrome. YES NO

8) Optimal medical therapy with Beta Blocker and ACE/ARB? YES NO

List: _____

9) CABG or PTCA in last 3 months? YES NO

10) MI in past 40 days? YES NO

11) Are they a candidate for reperfusion? YES NO N/A

12) Comorbid conditions: List _____

13) Likelihood of survival less than 1 year? YES NO

14) Anticoagulation? Plavix Coumadin N/A

Referring Physician (Name and phone number)

Fax request to : 717-531-7969