ICD PATIENT CLEARANCE FORM

TO BE COMPLETED BY SCHEDULING PHYSICIAN'S OFFICE (please print)

Physician: ____ Scheduler: _______________________

Patient Full Name: ____ D.O.B ___________________

D.O.S.: ___________________ Procedure Description: ____

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Type of anesthesia to be used: ❒ **MAC** ❒ **GENERAL**

The Physician intends to use the unipolar bovie: ❒ **YES** ❒ **NO**

TO BE COMPLETED BY ELECTROPHYSIOLOGIC PHYSICIAN (EP) (please print)

EP Name: ____ Phone: (_____) _________________

Type of Internal Cardioverter-Defibrillator (ICD): ____

Identification of patient's underlying rhythm: ____

Date of last antitachycardia "shock": ____

Remaining length of battery life: ____________ Length of last capacitor charge time: ____________

What effect does a magnet have on this particular ICD? ____

If a magnet is used on this ICD, will the patient require a POST-OPERATIVE ICD EXAM by an EP Physician BEFORE discharge from St. Louis Eye Surgery & Laser Center? ❒ **YES*** ❒ **NO**

** must be arranged IN ADVANCE by scheduling physician's office, EP Physician's Office and patient.*

Patient may proceed with surgery and anesthesia as described above: ❒ **YES** ❒ **NO**

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Signature of Electrophysiologic Physician Date