St. Charles Surgery Center

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: _____

_____

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**

_____ _____

Signature of Electrophysiologic Physician Date