56591

AVID

ICD Implantation

Fax to: (206) 685-7569
or (800) 253-6404

Complete this form for each attempted or successful implantation, lead repositioning, lead replacement, or ICD explantation. Complete a separate form for each attempt.

Affix Patient ID # Here seqnum10

1 Date of Implantation: days10

Month / Day / Year

Time procedure began: tmproc10
(24 hour clock)

2 Is this procedure (check all applicable):

origim10 O Original generator & lead implantation
gnonly10 O Original generator-only implantation
ldonly10 O Original lead-only implantation
ldrepo10 O Lead repositioning (Skip items 5 and 9)
gnrepl10 O Generator replacement
ldrepl10 O Lead replacement
explnt10 O Explantation, no replacement (Skip items 5, 10,11, and 12)
noimpl10 O No implantation will be attempted (Complete item 12 only)

Complete a Lead and Generator Identification form for any leads/generator implanted, explanted, or repositioned. Complete ICD Complications form 30 days after implant and ICD Evaluation form at hospital discharge.

Important:

If this replacement is due to a generator or lead system failure other than normal battery depletion, notify the CTC immediately by FAX and verbally by telephone call. Notification should be made immediately, but in any case, is required within 10 working days of discovery of the malfunction.

If replacement or explantation, which components were replaced or explanted?

gnrep210 O Generator. If yes, specify reason:

genbat10
0 O Battery replacement for end of life (does NOT require special notification to CTC).
Months in use: batmon10
1 O Other, specify:

ldrep210 O Lead replacement/repositioning. If yes, specify reason:

lead10
0 O Dislodgement (does NOT require special notification to CTC)
1 O Other, specify:

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Date of implantation: ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

☐☐-☐☐☐-☐ ☐☐☐☐ Affix Patient ID # Here

locat10 **3 Location of procedure (check one):** ○ OR (1) ○ Cath/EP lab (2)

4 Participating physicians (check one on each applicable line):

		Primarily Electrophysiologist (1)	Primarily Surgeon (2)	Combined Equal Effort (3)	Other (4)	Not done (0)
oplead10	Leads:	○	○	○	○	○
oppock10	Pocket:	○	○	○	○	○
opep10	EP/Device Testing:	○	○	○	○	○

5 Route of implantation: route10

1 ○ NTL 2 ○ Median sternotomy 3 ○ Thoracotomy
4 ○ Subcostal 5 ○ Subxiphoid 6 ○ Thoracoscopy

For NTL, route of insertion: ntlins10

1 ○ Subclavian
2 ○ Cephalic
3 ○ Other: ☐☐☐☐☐☐☐☐☐☐☐☐

Location of generator: locgen10

1 ○ Abdominal
2 ○ Pectoral
3 ○ Other: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

6 Duration of procedure: tmdur10 ☐☐ : ☐☐ (hours : minutes) *("skin-to-skin" time)*

7 Anesthesia:

Anesthesia type (check one): antype10

1 ○ General with intubation
2 ○ General without intubation
3 ○ Conscious sedation

anpres10 Anesthesiologist/Anesthetist present? ○ Yes (1) ○ No (0)

8 Use of antibiotics (check all that apply): ○ Pre-op abpre10 ○ Intra-op abintr10 ○ Post-op abpost10 ○ Not used abnone10

9 Irrigation of pocket with antibiotics? irrab10 ○ Yes (1) ○ No (0)

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Date of implantation:

Month / Day / Year

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10 Were any of the following procedures performed at the time of implantation of the device?

	Yes	No	Procedure	*If yes, give details:*
bypass10	O	O	Coronary artery bypass graft surgery . .	Number of vessels grafted: vessel10
valve10	O	O	Heart valve repair/replacement	O Mitral valve mitral10 O Aortic valve aortic10 O Tricuspid valve tricus10
aneur10	O	O	Aneurysm surgery	

Total time on cardiopulmonary bypass: (hh:mm) : tmbyp10

11 Defibrillation threshold:

dfttst10 Were three energies tested and successful? O Yes (1) O No (0)

saftyj10 Was a 10 Joule safety margin achieved? O Yes (1) O No (0)

12 Was the implantation successful (both leads and generator properly functioning)?

succes10 (1 / 0) O Yes O No

If no, why not?

whyuns10

1 O Inadequate DFT

2 O Unable to position leads

3 O Patient clinically unstable

5 O Planned to insert leads only

4 O Other:

Signature of person filling out this form

code number

For Clinical Trial Center Use Only: rtnum10

CTC Code | Yes O | No O | 2 | 1 0 | 0 6 0 0