# CRTD or ICD Implantation Criteria Checklist

(ACC / AHA / HRS Device Therapy Guidelines)

Fax to: Central Scheduling (912)389–2165 and Cath Lab (912)383–5664

Patient: DOB: MRN#

Provider: Date:

| | | | |
|---|---|---|---|
| 1. | Patients NYHA Classification: | ❑ I ❑ II ❑ III ❑ IV | |
| 2. | Patients QRS duration on ECG: | ________ms | |
| 3. | Has the patient undergone a heart catheterization with PCI/STENT?: | ❑ Yes | Date: |
| 4. | Has the patient undergone a CABG Surgery revascularization?: | ❑ Yes | Date: |
| 5. | Patients Ejection fraction on echocardiogram: | _________% | ECHO Date: |
| 6. | Is the patient on OMT (Optimal Medical Therapy): | ❑ Yes | ❑ No |
| 7. | Patient expectation of survival with good functional status of > 1 year: | ❑ Yes | ❑ No |

| | **CRT–D Therapy** | | **ICD TCD Therapy*** |
|---|---|---|---|
| | NYHA CLass III, IV | | NYHA Class I, LVEF ≤ 30% |
| | LVEF VEF ≥ 35% | | NYHA Class II, III LVEF ≤ 35% |
| | QRS S ≥ 120 0 ms | | 40 days post– MI |
| | | | Nonischemic DCM |

| | | |
|---|---|---|
| Patient meets above guideline criteria for CRT–D Therapy : | Yes ❑ | No ❑ |
| Patient meets above guideline criteria for ICD Therapy : | Yes ❑ | No ❑ |
| Consider referral for device upgrade: | Yes ❑ | No ❑ |

**Additional Comments:**

In order to support documentation requirements for ICD implants, the actual report(s) of the necessary clinical data must be in the patient's medical record at the facility of implantation. The necessary clinical data include:

1. Pertinent EKG and EP recordings
2. LVEF (by angiography, radionuclide imaging, echocardiography or MRI)
3. Pertinent progress notes or office notes
4. Cardiac resuscitation records if present
5. Any additional information to support the procedure.

Physician Signature : ______________________________ Date/Time: ________________



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