



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:	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV
2.	Patients QRS duration on ECG:	_____ms
3.	Has the patient undergone a heart catheterization with PCI/STENT?:	<input type="checkbox"/> Yes Date: _____
4.	Has the patient undergone a CABG Surgery revascularization?:	<input type="checkbox"/> Yes Date: _____
5.	Patients Ejection fraction on echocardiogram:	_____ % ECHO Date: _____
6.	Is the patient on OMT (Optimal Medical Therapy):	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Patient expectation of survival with good functional status of > 1 year:	<input type="checkbox"/> Yes <input type="checkbox"/> No

<u>CRT-D Therapy</u>	<u>ICD TCD Therapy*</u>
NYHA CClass 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 <input type="checkbox"/>	No <input type="checkbox"/>
Patient meets above guideline criteria for ICD Therapy :	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Consider referral for device upgrade:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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: _____