

## S-ICD Implant

Center Code: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Subject Initials Name/Surname: \_\_\_\_/\_\_\_\_

Implant data	
Implant date: __/__/__	
Device Manufacturer: _____ Device model: _____	
Factors for preferring an S-ICD:	<input type="checkbox"/> Young age <input type="checkbox"/> Long life expectancy <input type="checkbox"/> Prevention/resolution of complications of transvenous lead <input type="checkbox"/> Prevention/resolution of infective complications (diabetes, renal insufficiency) <input type="checkbox"/> Specific detection algorithm <input type="checkbox"/> Cosmetic appearance <input type="checkbox"/> Patient preference <input type="checkbox"/> Other: _____
Driver for implanting an S-ICD:	<input type="checkbox"/> Physician choice <input type="checkbox"/> Patient choice <input type="checkbox"/> Only option <input type="checkbox"/> Problems with the previous transvenous system <input type="checkbox"/> Other: _____
Previous implanted device:	<input type="checkbox"/> NO <input type="checkbox"/> PM <input type="checkbox"/> ICD <input type="checkbox"/> CRT-P <input type="checkbox"/> CRT-D <input type="checkbox"/> S-ICD <input type="checkbox"/> _____  Previous implant date: __/__/__ Battery: <input type="checkbox"/> BOL <input type="checkbox"/> MOL <input type="checkbox"/> ERI <input type="checkbox"/> EOL  Delivered therapies? <input type="checkbox"/> NO <input type="checkbox"/> Appropriate <input type="checkbox"/> Inappropriate <input type="checkbox"/> Both  If S-ICD replacement: <input type="checkbox"/> clinical indication <input type="checkbox"/> elective replacement
Previous implanted leads:	<input type="checkbox"/> NO <input type="checkbox"/> RA <input type="checkbox"/> RV PM <input type="checkbox"/> RV ICD <input type="checkbox"/> LV <input type="checkbox"/> Other _____
System/lead extraction?	<input type="checkbox"/> NO <input type="checkbox"/> YES, date _____ <input type="checkbox"/> Device <input type="checkbox"/> Lead, specify: _____
Hybrid implant (PM, Leadless PM, CRT-P)?	<input type="checkbox"/> NO <input type="checkbox"/> YES, specify: _____ _____  PM implant date: _____
Additional information: _____	

Device programming (prior to patient discharge)	
<b>Conditional zone (bpm):</b>	<input type="checkbox"/> No <input type="checkbox"/> 170 <input type="checkbox"/> 180 <input type="checkbox"/> 190 <input type="checkbox"/> 200 <input type="checkbox"/> 210 <input type="checkbox"/> 220 <input type="checkbox"/> 230 <input type="checkbox"/> 240
<b>Shock zone (bpm):</b>	<input type="checkbox"/> 170 <input type="checkbox"/> 180 <input type="checkbox"/> 190 <input type="checkbox"/> 200 <input type="checkbox"/> 210 <input type="checkbox"/> 220 <input type="checkbox"/> 230 <input type="checkbox"/> 240 <input type="checkbox"/> 250
<b>Shock polarity:</b>	<input type="checkbox"/> Standard <input type="checkbox"/> Reversed
<b>Pacing post-shock:</b>	<input type="checkbox"/> NO <input type="checkbox"/> YES
<b>Sensing vector:</b>	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Alternate
<b>Gain:</b>	<input type="checkbox"/> 1x <input type="checkbox"/> 2x
<b>Sensing optimization:</b>	<input type="checkbox"/> NO <input type="checkbox"/> YES
<b>Sensing Setup :</b>	<input type="checkbox"/> Automatic <input type="checkbox"/> Manual
<b>Reason for manual setup:</b>	_____
<b>Template acquisition:</b>	<input type="checkbox"/> NO <input type="checkbox"/> YES
<b>SMART PASS :</b>	<input type="checkbox"/> NO <input type="checkbox"/> YES
<b>AF MONITOR:</b>	<input type="checkbox"/> NO <input type="checkbox"/> YES
<b>Additional information:</b>	_____
Remote Monitoring	
<b>Remote monitoring:</b>	<input type="checkbox"/> NO <input type="checkbox"/> YES
<b>Weekly alarm check:</b>	<input type="checkbox"/> NO <input type="checkbox"/> YES day of the week: _____
<b>Scheduled remote follow up :</b>	<input type="checkbox"/> NO <input type="checkbox"/> YES timing: _____
Procedure	
<b>Device placement:</b>	<input type="checkbox"/> Subcutaneous <input type="checkbox"/> Submuscular <input type="checkbox"/> Intermuscular (between the serratus anterior muscle and the latissimus dorsi muscle) <input type="checkbox"/> Other, specify : _____
<b>Lead placement:</b>	<input type="checkbox"/> Left parasternal <input type="checkbox"/> Right parasternal <input type="checkbox"/> Sternal midline <input type="checkbox"/> Other: _____
<b>Use of preimplant demo:</b>	<input type="checkbox"/> NO <input type="checkbox"/> YES
<b>Incisions number (with pocket):</b>	<input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other, specify _____
<b>Use of tunnelling during implant:</b>	<input type="checkbox"/> NO <input type="checkbox"/> YES, model: _____
<b>Skin-to-skin time:</b>	_____minutes
<b>Use of imaging system:</b>	<input type="checkbox"/> NO <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> X-Ray <input type="checkbox"/> Other, specify _____
	Time : _____minutes
<b>Available images?</b>	<input type="checkbox"/> NO <input type="checkbox"/> YES

**Anaesthesia:**  NO  YES

local  general  deep sedation  other, \_\_\_\_\_

anesthetic, specify \_\_\_\_\_

**Operating room:**  EP Lab  Surgical Theatre **Operators number:** \_\_\_\_

**Hospitalization:**  day hospital  > 1day  Other, \_\_\_\_\_

**Defibrillation testing:**  NO  YES

**If not, indicate the reason:**

**Clinical reason:**  patient condition  poor EF  
 primary prevention  clinical practice  
 lackness of anesthetist  patient refusal  
 Other, \_\_\_\_\_

**Technical reason:**  VF induction not achieved :  
number of tests \_\_\_\_ ;  
50Hz : \_\_\_\_\_ seconds (s)

**If done:**

Successful conversion with the first shock?  NO  YES  
Delivered energy: \_\_\_\_ J Shock impedance: \_\_\_\_\_ Ohm  
Shock polarity:  STD  REV

if NOT successful, specify which cardioversion has been effective (internal /external shock):  
 2°  3°  4°  5° Shock impedance: \_\_\_\_\_ Ohm  
 External defibrillator  
Number of ineffective shocks: \_\_\_\_\_

Indicate the action taken:

Test at higher energy; Delivered energy: \_\_\_\_ J  
 Test at alternate polarity  
 Reposition of the lead  
 Reposition of the device

Time to the first therapy: \_\_\_\_\_ s  
Sensing post-shock:  Appropriate  Inappropriate  
Pacing post-shock:  Appropriate  Inappropriate  
Pacing post-shock duration: \_\_\_\_ s

**Further defibrillation testing:**  NO  YES

Successful conversion with the first shock?  NO  YES  
Delivered energy: \_\_\_\_ J Shock impedance: \_\_\_\_\_ Ohm  
Shock polarity:  STD  REV

if NOT successful, specify which cardioversion has been effective (internal /external shock):  
 2°  3°  4°  5° Shock impedance: \_\_\_\_\_ Ohm

External defibrillator

Number of ineffective shocks: \_\_\_\_\_

Indicate the action taken:

- Test at higher energy; Delivered energy: \_\_\_ J
- Test at alternate polarity
- Reposition of the lead
- Reposition of the device

Time to the first therapy: \_\_\_\_\_s

Sensing post-shock:  Appropriate  Inappropriate

Pacing post-shock:  Appropriate  Inappropriate

Pacing post-shock duration: \_\_\_s

Additional information \_\_\_\_\_