

Complete all applicable information, as available and as permitted by law, and transmit to Boston Scientific CRM, Medical Records. US regulations require that distribution and/or implant of devices be tracked and reported to Boston Scientific. Also transmit data from the programmer, such as patient data and QUICK NOTES™.

Use the tab key to quickly move from field to field. Hover the cursor over any field to display a completion hint. Print form and place labels of product information, if desired.

Patient Information

Last Name: _____ First Name: _____ Middle: _____ Suffix: _____ Gender: Male Female
 Street: _____ City: _____ State: _____ Country: _____ ZIP+4: _____
 Phone: _____ SSN: _____ DOB: _____ Weight: _____ MR #: _____

Indications for Therapy

Indications for Therapy (Primary): _____ Indications for Therapy (Other): _____

Physician and Hospital Information

Implanting MD Last Name: _____ First Name: _____ Middle: _____ Suffix: _____ Specialty: _____ Phone: _____
 Street: _____ City: _____ State: _____ ZIP+4: _____ Country: _____
Following MD Last Name: _____ First Name: _____ Middle: _____ Suffix: _____ Specialty: _____ Phone: _____
 Street: _____ City: _____ State: _____ ZIP+4: _____ Country: _____
Referring MD Last Name: _____ First Name: _____ Middle: _____ Suffix: _____ Specialty: _____ Phone: _____
 Street: _____ City: _____ State: _____ ZIP+4: _____ Country: _____

Implanting Facility Name: _____ Country: _____
 Street: _____ City: _____ State: _____ ZIP+4: _____ Phone: _____

Implanted Device Information

Device Type: _____
 Implant Date: _____ Manufacturer: _____ Model: _____ SN: _____ Implant Location: _____ Side of Body: _____
Programmed Parameters: Pacing Mode: _____ LRL: _____ ppm URL: _____ ppm AV Delay: _____ ms PVARP: _____ ms
 V Refractory: _____ ms AV Search VRR Atrial Tachy Response Sudden Brady Response

Lead/Adapter Information

Implant Date: _____ Manufacturer: _____ Model: _____ SN: _____ Polarity: _____ Position: _____
 Implant Date: _____ Manufacturer: _____ Model: _____ SN: _____ Polarity: _____ Position: _____
 Implant Date: _____ Manufacturer: _____ Model: _____ SN: _____ Polarity: _____ Position: _____
 Implant Date: _____ Manufacturer: _____ Model: _____ SN: _____ Polarity: _____ Position: _____
 Implant Date: _____ Manufacturer: _____ Model: _____ SN: _____ Polarity: _____ Position: _____

Measured Data

| Lead | Sensing Amplitude | Pacing Impedance | Shocking Impedance | Pulse Width | Threshold | Current | DFT | A Fib |
|------|-----------------------------------|------------------|--------------------|-------------|-----------|---------|-----|-------|
| | mV <input type="checkbox"/> Paced | ohms | ohms | ms | V | mA | J | |
| | mV <input type="checkbox"/> Paced | ohms | ohms | ms | V | mA | J | |
| | mV <input type="checkbox"/> Paced | ohms | ohms | ms | V | mA | J | |
| | mV <input type="checkbox"/> Paced | ohms | ohms | ms | V | mA | J | |
| | mV <input type="checkbox"/> Paced | ohms | ohms | ms | V | mA | J | |

Concomitant pacemaker? No Yes Manufacturer: _____ Model: _____ SN: _____ Polarity: _____ Mode: _____

If complications were experienced during implant, contact Boston Scientific.

Explanted, Attempted, or Wasted Information

Were any devices explanted, attempted, or wasted during implant? No Yes If yes, complete the following information.

Type: _____ Manufacturer: _____ Model: _____ SN: _____ Implant Date: _____ Explant Date: _____
 Reason: _____ Status: _____
 Type: _____ Manufacturer: _____ Model: _____ SN: _____ Implant Date: _____ Explant Date: _____
 Reason: _____ Status: _____
 Type: _____ Manufacturer: _____ Model: _____ SN: _____ Implant Date: _____ Explant Date: _____
 Reason: _____ Status: _____

Defibrillation Testing

Test 1 Charge Time: _____^{sec} Energy: _____ J Impedance: _____ Ω RV Vector: _____ Result: _____
 Test 2 Charge Time: _____^{sec} Energy: _____ J Impedance: _____ Ω RV Vector: _____ Result: _____
 Test 3 Charge Time: _____^{sec} Energy: _____ J Impedance: _____ Ω RV Vector: _____ Result: _____

Comments: _____

Form completed by: Name: _____ Phone: _____ Date: _____
 Position/Title: _____ Company: _____