Medtronic

SYSTEM REGISTRATION

A12491001

The information you provide on this form is necessary for Medtronic to meet its obligations regarding product safety, efficacy and quality surveillance, including device tracking, product performance, monitoring or reporting as well as warranty protection.

ACTIVE DEVICE DATA (LIST NEW OR EXISTING LEADS) (USE STICKERS IF AVAILABLE)

✓ CORRECT BOX			MODEL NUMBER	SERIAL NUMBER	IMPLANT DATE	MANUFACTURER
☐ IPG ☐ ICD ☐ CRT-P ☐ CRT-D ☐ OTHER					☐ Check if same day as device MM / DD / YYYY	
LEADS	RIGHT ATRIUM	ACUTE ☐ CHRONIC ☐			☐ Check if same day as device MM / DD / YYYY	
LEADS	RIGHT VENTRICLE	ACUTE ☐ CHRONIC ☐			☐ Check if same day as device MM / DD / YYYY	
LEADS	☐ SVC ☐ CS ☐ LA ☐ LV	ACUTE ☐ CHRONIC ☐			☐ Check if same day as device MM / DD / YYYY	
LEADS	☐ SVC ☐ CS ☐ _____	ACUTE ☐ CHRONIC ☐			☐ Check if same day as device MM / DD / YYYY	

IMPLANT SITE

☐ ABDOMINAL ☐ PECTORAL ☐ OTHER _____

ADAPTOR(S)/PATCHES: WRITE IN MODEL SERIAL NUMBERS BELOW

PREVIOUS DEVICE DATA (COMPLETE THIS SECTION IF THIS IS A REPLACEMENT IMPLANT AND THE FOLLOWING DEVICES ARE NO LONGER IN USE)

MODEL NUMBER	SERIAL NUMBER	MANUFACTURER	LEAD/ADAPTOR MODEL NUMBER	LEAD/ADAPTOR SERIAL NUMBER	MANUFACTURER
LEAD/ADAPTOR MODEL NUMBER	**LEAD/ADAPTOR SERIAL NUMBER**	**MANUFACTURER**	**LEAD/ADAPTOR MODEL NUMBER**	**LEAD/ADAPTOR SERIAL NUMBER**	**MANUFACTURER**

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INT) | PARENT/GUARDIAN (IF APPLICABLE) | SOCIAL SECURITY NUMBER (US ONLY) - -

MAILING ADDRESS | APT. NUMBER | CITY, STATE/PROVINCE, POSTAL CODE | COUNTRY

PHONE NUMBER | PATIENT'S E-MAIL ADDRESS | DATE OF BIRTH MM / DD / YYYY | GENDER ☐ MALE ☐ FEMALE

IMPLANT HOSPITAL

NAME | CITY, STATE/PROVINCE | PHONE NUMBER | PROCEDURE LOCATION ☐ O.R. ☐ E.P./CATH LAB ☐ OTHER _____ | PROCEDURE DURATION _____ HRS.

IMPLANTING PHYSICIAN (IF NOT FOLLOW-UP PHYSICIAN, PLEASE COMPLETE SECTION BELOW)

PHYSICIAN NAME (LAST, FIRST, MIDDLE INT) | DOCTOR'S E-MAIL ADDRESS

OFFICE ADDRESS & SUITE # | CITY, STATE/PROVINCE, POSTAL CODE | COUNTRY | PHONE NUMBER

ATTENDING / FOLLOW-UP PHYSICIAN (WILL BE LISTED ON I.D. CARD) SAME AS ABOVE ☐

PHYSICIAN NAME (LAST, FIRST, MIDDLE INT) | DOCTOR'S E-MAIL ADDRESS

OFFICE ADDRESS & SUITE # | CITY, STATE/PROVINCE, POSTAL CODE | COUNTRY | PHONE NUMBER

REFERRING PHYSICIAN (PHYSICIAN WHO REFERRED PATIENT FOR IMPLANT)

PHYSICIAN NAME (LAST, FIRST, MIDDLE INT) | DOCTOR'S E-MAIL ADDRESS

OFFICE ADDRESS & SUITE # | CITY, STATE/PROVINCE, POSTAL CODE | COUNTRY | PHONE NUMBER

INDICATIONS

ICD INDICATIONS	PRIMARY (CHECK ONE)	SECONDARY (CHECK ANY)
Prior Sudden Cardiac Arrest/VF	☐	☐
History of Spontaneous Sustained VT	☐	☐
Genetic: LQTS, HCM, Brugada	☐	☐
Post MI, low EF, no history VT/VF (MADIT-II)	☐	☐
Low EF, no history VT/VF (SCD-HeFT)	☐	☐
Atrial Fibrillation	☐	☐
Other: _____	☐	☐
RESYNCHRONIZATION INDICATIONS		
Low EF, Dyssynchrony (wide QRS)	☐	☐
Low EF, Dyssynchrony (wide QRS), No ICD	☐	☐
Other: _____	☐	☐

Was an ILR used to make diagnosis YES ☐ NO ☐

PACING INDICATIONS	PRIMARY (CHECK ONE)	SECONDARY (CHECK ANY)
Sinus Bradycardia	☐	☐
Brady/Tachy Syndrome	☐	☐
Drug-Induced Brady	☐	☐
Other Sinus Node Dysfunction / SSS	☐	☐
AV Block (3rd degree, Complete HB)	☐	☐
AV Block (2nd degree, Mobitz II)	☐	☐
AV Block (unspecified/ incomplete)	☐	☐
Bundle Branch Block (all forms)	☐	☐
CSS (Carotid Sinus Syndrome)	☐	☐
VVS (Vaso-vagal Syncope) / Neurocardiogenic	☐	☐
HOCM (Hypertrophic Obstructive Cardiomyopathy)	☐	☐
AV Node Ablation	☐	☐
Other: _____	☐	☐

OTHER PATIENT CHARACTERISTICS	(CHECK ANY)
Ejection Fraction: ____%	
QRS Duration: ____ms	
NYHA Class I	☐
NYHA Class II	☐
NYHA Class III	☐
NYHA Class IV	☐
AT, AF, A-FI	☐
PSVT, SVT	☐
Previous MI	☐
Cardiomyopathy	☐
Valve Disease	☐
Transplant	☐
Other: _____	☐

LEAD MEASUREMENTS AS MEASURED BY PSA OR EQUIVALENT

PACING/SENSING - RIGHT ATRIUM

THRESHOLDS: VOLTAGE ____.__ V CURRENT ____.__ mA | IMPEDANCE: _____ ohms

POLARITY: ☐ BIPOLAR ☐ UNIPOLAR | SENSING: P-WAVE ____.__ mV

PACING/SENSING - RIGHT VENTRICLE

THRESHOLDS: VOLTAGE ____.__ V CURRENT ____.__ mA | IMPEDANCE: _____ ohms

POLARITY: ☐ BIPOLAR ☐ UNIPOLAR | SENSING: R-WAVE ____.__ mV

PACING/SENSING - ☐ LA ☐ LV

THRESHOLDS: VOLTAGE ____.__ V CURRENT ____.__ mA | IMPEDANCE: _____ ohms

POLARITY: ☐ BIPOLAR ☐ UNIPOLAR ☐ TIP-COIL

COMMENTS:

DEFIBRILLATION LEAD MEASUREMENTS ☐ A ☐ V

HIGH VOLTAGE PATHWAY: | IMPEDANCE _____ ohms

DFT/LED _____ J

LEFT VENTRICULAR LEAD TIP LOCATION:

☐ POSTERIOR and ☐ BASAL or ☐ MID
☐ LATERAL and ☐ BASAL or ☐ MID
☐ ANTERIOR and ☐ BASAL or ☐ MID
☐ APICAL

PARAMETER SETTINGS

PACING MODE _____ LOWER RATE ____ ppm UPPER TRACKING RATE ____ ppm UPPER ACTIVITY RATE ____ ppm

IF DEVICE, LEAD OR CONNECTOR WAS NOT IMPLANTED (USE STICKERS IF AVAILABLE)

☐ RETURNED TO MEDTRONIC (PREFERRED)
☐ DISCARDED

MODEL/SERIAL NUMBER

PERSON TO CONTACT REGARDING REGISTRATION INFORMATION

NAME AND TITLE | PHONE NUMBER

Medtronic, Inc.
7000 Central Avenue NE
Minneapolis, MN 55432
Tel: (800) 328-2518

Medtronic of Canada Ltd.
6733 Kitimat Road
Mississauga, Ontario L5N 1W3
Tel: (800) 268-5346

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UC200600152
A12491001 Rev C

Medtronic

SYSTEM REGISTRATION

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✓ CORRECT BOX		MODEL NUMBER	SERIAL NUMBER	IMPLANT DATE	MANUFACTURER
☐ IPG ☐ CRT-P ☐ OTHER ☐ ICD ☐ CRT-D				☐ Check if same day as device MM / DD / YYYY	
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	RIGHT VENTRICLE	ACUTE ☐ CHRONIC ☐			☐ Check if same day as device MM / DD / YYYY	
	☐ SVC ☐ CS ☐ LA ☐ LV	ACUTE ☐ CHRONIC ☐			☐ Check if same day as device MM / DD / YYYY	
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IMPLANT SITE	ADAPTOR(S)/PATCHES: WRITE IN MODEL SERIAL NUMBERS BELOW
☐ ABDOMINAL ☐ PECTORAL ☐ OTHER _____	_____

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LEAD/ADAPTOR MODEL NUMBER	LEAD/ADAPTOR SERIAL NUMBER	MANUFACTURER	LEAD/ADAPTOR MODEL NUMBER	LEAD/ADAPTOR SERIAL NUMBER	MANUFACTURER

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IMPLANT HOSPITAL

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History of Spontaneous Sustained VT	☐	☐
Genetic: LQTS, HCM, Brugada	☐	☐
Post MI, low EF, no history VT/VF (MADIT-II)	☐	☐
Low EF, no history VT/VF (SCD-HeFT)	☐	☐
Atrial Fibrillation	☐	☐
Other: _____	☐	☐
RESYNCHRONIZATION INDICATIONS		
Low EF, Dyssynchrony (wide QRS)	☐	☐
Low EF, Dyssynchrony (wide QRS), No ICD	☐	☐
Other: _____	☐	☐

Was an ILR used to make diagnosis YES ☐ NO ☐

PACING INDICATIONS	PRIMARY (CHECK ONE)	SECONDARY (CHECK ANY)
Sinus Bradycardia	☐	☐
Brady/Tachy Syndrome	☐	☐
Drug-Induced Brady	☐	☐
Other Sinus Node Dysfunction / SSS	☐	☐
AV Block (3rd degree, Complete HB)	☐	☐
AV Block (2nd degree, Mobitz II)	☐	☐
AV Block (unspecified/ incomplete)	☐	☐
Bundle Branch Block (all forms)	☐	☐
CSS (Carotid Sinus Syndrome)	☐	☐
VVS (Vaso-vagal Syncope) / Neurocardiogenic	☐	☐
HOCM (Hypertrophic Obstructive Cardiomyopathy)	☐	☐
AV Node Ablation	☐	☐
Other: _____	☐	☐

OTHER PATIENT CHARACTERISTICS	(CHECK ANY)
Ejection Fraction: ____%	
QRS Duration: ____ms	
NYHA Class I	☐
NYHA Class II	☐
NYHA Class III	☐
NYHA Class IV	☐
AT, AF, A-Fl	☐
PSVT, SVT	☐
Previous MI	☐
Cardiomyopathy	☐
Valve Disease	☐
Transplant	☐
Other: _____	☐

LEAD MEASUREMENTS AS MEASURED BY PSA OR EQUIVALENT

PACING/SENSING - RIGHT ATRIUM

THRESHOLDS: VOLTAGE ___.___ V CURRENT ___.___ mA | IMPEDANCE: _____ ohms

POLARITY: ☐ BIPOLAR ☐ UNIPOLAR | SENSING: P-WAVE ___.___ mV

PACING/SENSING - RIGHT VENTRICLE

THRESHOLDS: VOLTAGE ___.___ V CURRENT ___.___ mA | IMPEDANCE: _____ ohms

POLARITY: ☐ BIPOLAR ☐ UNIPOLAR | SENSING: R-WAVE ___.___ mV

PACING/SENSING - ☐ LA ☐ LV

THRESHOLDS: VOLTAGE ___.___ V CURRENT ___.___ mA | IMPEDANCE: _____ ohms

POLARITY: ☐ BIPOLAR ☐ UNIPOLAR ☐ TIP-COIL

COMMENTS:

DEFIBRILLATION LEAD MEASUREMENTS ☐ A ☐ V

HIGH VOLTAGE PATHWAY: | IMPEDANCE _____ ohms

DFT/LED _____ J

LEFT VENTRICULAR LEAD TIP LOCATION:

☐ POSTERIOR	and	☐ BASAL	or	☐ MID	
☐ LATERAL	and	☐ BASAL	or	☐ MID	
☐ ANTERIOR	and	☐ BASAL	or	☐ MID	
☐ APICAL					

PARAMETER SETTINGS

PACING MODE _____ LOWER RATE ___ ppm UPPER TRACKING RATE ___ ppm UPPER ACTIVITY RATE ___ ppm

IF DEVICE, LEAD OR CONNECTOR WAS NOT IMPLANTED (USE STICKERS IF AVAILABLE)

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NAME AND TITLE | PHONE NUMBER

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7000 Central Avenue NE
Minneapolis, MN 55432
Tel: (800) 328-2518

Medtronic of Canada Ltd.
6733 Kitimat Road
Mississauga, Ontario L5N 1W3
Tel: (800) 268-5346

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