

INCOR/EXCOR PRE-IMPLANT FORM

SEND BY FAX (+ 49 – 30 – 81 87 27 37) or E-MAIL (service@berlinheart.de)

Hospital	City	Country
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PATIENT INFORMATION

Patient Initials	Gender m <input type="checkbox"/> f <input type="checkbox"/>	Age [years]	Size [cm]	Weight [kg]
Indication	idiopathic CMP <input type="checkbox"/>	ischemic CMP <input type="checkbox"/>	acute myocardial infarction <input type="checkbox"/>	myocarditis <input type="checkbox"/>
	postcardiotomy <input type="checkbox"/>	other <input type="checkbox"/> _____		
Intention to treat	bridge to recovery <input type="checkbox"/>	destination therapy <input type="checkbox"/>	bridge to transplantation <input type="checkbox"/>	

PRE-IMPLANT CONDITION

Urgency of implantation elective <input type="checkbox"/> urgent <input type="checkbox"/> emergency <input type="checkbox"/>	CPR within 24 h no <input type="checkbox"/> yes <input type="checkbox"/>
NYHA class III <input type="checkbox"/> IV <input type="checkbox"/>	Dialysis/Hemofiltration within 72 h no <input type="checkbox"/> yes <input type="checkbox"/>
Days on ventilator _____ Inotropes no <input type="checkbox"/> yes <input type="checkbox"/>	History of stroke no <input type="checkbox"/> yes <input type="checkbox"/>
ECMO no <input type="checkbox"/> yes <input type="checkbox"/> since _____ days	History of prev. thor. surg. no <input type="checkbox"/> yes <input type="checkbox"/>
IABP no <input type="checkbox"/> yes <input type="checkbox"/> since _____ days	If yes, please specify: _____
Other MCS no <input type="checkbox"/> yes <input type="checkbox"/> since _____ days	Prior Anticoagulation no <input type="checkbox"/> yes <input type="checkbox"/>
	If yes, please mark: Warfarin - Clopidogrel - ASA

PRE-IMPLANT HEMODYNAMICS/Echocardiography (if a parameter is not available please mark: n.a.)

MAP [mmHg]	CVP [mmHg]	PAP mean [mmHg]	LVEDP / PCWP [mmHg]	LVEF [%]
Cardiac Output [l/min]	Cardiac Index [l/min/sqm]	MR Grade [1-4]	LVEDD [mm]	RVEF [%]
TR Grade [1-4]	RV longitudinal diameter [mm]	RV transverse diameter [mm]	TAPSE [mm]	

PRE-IMPLANT LABORATORY DATA (if a parameter is not available please mark: n. a.)

BUN [Unit?]	Creatinine [Unit?]	Total Bilirubin [Unit?]	CRP [Unit?]	NT pro BNP [Unit?]
Lactate [Unit?]	Leucocytes [Unit?]	Platelets [Unit?]	INR	AST (GOT) [Unit?]

NEED FOR CLINICAL SUPPORT

Do you require clinical support from our staff?	no <input type="checkbox"/> yes <input type="checkbox"/>
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needed for assessment of RV function (preoperative evaluation LVAD / BVAD)