Abbott Medical
15900 Valley View Court
Sylmar, CA 91342 USA
1 800 777 2237
1 818 362 6822

CONFIDENTIAL

Removed Device Information

For the safety of our employees, we request that all devices be enclosed in a protective cover.
Please Print or Type

Patient _____ (Last Name) (First Name) (Middle Initial)

Social Security # _____ Date of Birth _____

Explanting Physician _____ (Last Name) (First Name) (Middle Initial)

Hospital _____

Address _____ (Street) (City) (State) (Zip Code)

Person to contact for further information. (When applicable, the explanting physician will receive information resulting from analysis of returned product, unless another name is specified below.)

_____ Name (please print legibly)

_____ Form Completed by Date

Phone (_____) _____

	Model	Serial	Date Implanted	Not Implanted	Removed	Capped	Date
Removed Pulse Generator				☐	☐	☒	
A				☐	☐	☐	
RV				☐	☐	☐	
LV				☐	☐	☐	

REASON(S) FOR REMOVAL/RETURN [Check ✓ appropriate box(es) and/or provide relevant comments]

Pulse Generator/ICD

- ☐ Back-Up Operation
- ☐ Capture Anomaly: ☐None ☐Intermittent
- ☐ Elective Replacement (describe below)
- ☐ ERI/EOL
- ☐ High Pacing Threshold
- ☐ Inappropriate Shock
- ☐ Microprocessor Reset
- ☐ Noise: ☐A ☐RV ☐LV
- ☐ Output Anomaly: ☐None ☐Intermittent
- ☐ Opened in Error
- ☐ Sensing Anomaly: ☐Over ☐Under ☐Intermittent
- ☐ Set Screw Anomaly
- ☐ Telemetry: ☐None ☐Intermittent
- ☐ Unable to Implant: ☐PT Related ☐Product Related
- ☐ Upgrade
- ☐ Programming: ☐None ☐Intermittent
- ☐ High DFT

Comments _____

Lead(s)

A	RV	LV	
☐	☐	☐	Capture Anomaly ☐None ☐Intermittent
☐	☐	☐	Clavicular Crush
☐	☐	☐	Connector Pin Bent
☐	☐	☐	Dislodgement
☐	☐	☐	Elective Replacement (describe below)
☒	☒	☐	Guidewire
☐	☐	☒	Helix: ☐Extension ☐Retraction ☐Damaged
☐	☐	☐	High Pacing Threshold
☒	☐	☒	Inappropriate Shock
☐	☐	☐	Insulation Anomaly
☐	☐	☐	Lead Impedance: ☐High ☐Low
☐	☐	☐	Lead Fracture
☐	☐	☐	Noise
☐	☐	☐	Opened in Error
☐	☐	☐	Sensing Anomaly: ☐Over ☐Under ☐Intermittent
☒	☐	☒	Shock Impedance: ☐High ☐Low
☐	☐	☐	Stylet
☐	☐	☐	Unable to Implant: ☐PT Related ☐Product Related

Comments _____

Patient/System Interface

- ☐ Exit Block
- ☐ Erosion
- ☐ Infection
- ☐ Muscle Stimulation
- ☐ Myopotential Oversensing
- ☐ Patient Death (Date _____)

Cause of death _____

☐ Does the Physician allege that the device may have caused or contributed to the event?
If yes, contact Technical Services.

Comments _____

PLEASE ENCLOSE ALL RELEVANT ECGs, PROGRAMMER PRINTOUTS, ACCESSORIES, DOCUMENTS, ETC.

MEASUREMENTS FROM REMOVED/REPLACED LEADS AT TIME OF PROCEDURE

Test Device _____

	Stimulation Threshold:	Sensing Amplitude:	Measured Impedance:
A	_____	_____	_____
RV	_____	_____	_____
LV	_____	_____	_____

Device was exposed to:

- ☐ Electrocautery
- ☐ Defibrillation/Cardioversion
- ☐ Other: _____

REPLACEMENT DEVICES

	Model	Serial
PG/ICD	_____	_____
A	_____	_____
RV	_____	_____
LV	_____	_____