Pioneer Cardiovascular
2149 E. Baseline Rd, Tempe, AZ 85283
PH(480) 345-0034 F(480)345-4033

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you feel better informed so you may give or withhold your consent to the procedure.*

I (we) voluntarily request Dr. _____, as my physician, associates and health care providers as they may deem necessary, to treat my condition which has been explained to me.

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures:

Loop Recorder Insertion_____
_____

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates and health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) understand that the physicians own the facility.

I (we) do understand that there is no on-site surgical back-up available at the facility.

I (we) do understand that at any time deemed necessary by my physician, I may be transferred by EMS to another facility for higher acuity of care.

I (we) **DO / DO NOT** authorize photograph/video or permit other persons to photograph/video my procedure for the purpose of teaching, education, and research purposes. I understand a videotape will not be maintained as part of my medical record.

I (we) understand that no warranty or guarantee has been made to me as a result to cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reaction, and even death.

I (we) understand that my physician may elect to have additional personnel, which may include but not limited to, vendor representatives in the room to facilitate the procedure.

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures.

Revised 02/18/2019

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I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death.

I (we) have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me, and I (we) have read it or had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

X _____
Patient or legally responsible person

Date: _____ Time: _____

X _____
Witness

Date: _____ Time: _____

I have discussed the following with the patient and/or significant other(s): The patient's proposed care and alternatives to proposed care, treatment, and services. The potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that may occur during recuperation; The circumstances under which information about the patient must be disclosed or reported, and when indicated, limitations on confidentiality of information learned from or about the patient.

X _____
Physician

Date: _____ Time: _____

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Loop Recorder Discharge Instructions

Wound Care

- **DO NOT** put any creams, gels, ointments, or lotions on incision.
- You may shower after 48 hours but must protect the incision site with a water proof bandage. Dressing will be removed at follow up appointment.
- **DO NOT** soak the incision wet. If the incision should accidentally become wet, pat dry. Do not rub.
- **Apply ice over incision as needed**

Notify your physician if:

- Unusual redness or drainage from the wound
- Increased swelling over the device
- Fever of greater than 100.5 degrees or chills

Resuming Normal Activities:

- Avoid extreme activities such as pulling, pushing, or lifting motions for 1 week.
- You should move your arm and shoulder gently to prevent stiffness
- You may experience some chest discomfort for several days after the procedure. It is usually relieved by an analgesic such as Tylenol. If it persists, call your physician.

Follow up Appointments:

- You should have received a follow up appointment when your Loop Recorder insertion was scheduled. If not, call your physician to schedule your appointment

What you can and cannot do:

- CT Scans and X-rays can be performed safely.
- **DO NOT** have an MRI without first consulting your physician
- Microwave ovens, electric blankets, and heating pads may be used

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Travel with your device:

- When traveling, let the airport personnel know that you have a Loop Recorder. The X-ray body scanner will not harm your device.

Smartphone App and Bluetooth:

- Your device communicates with your smartphone via Bluetooth. The device and phone should have been "paired" at implant. If not, please call your physician's office
- Keep the Bluetooth setting on your phone **turned ON**
- Keep your phone turned on at all times, and charge it every night on your nightstand closest to where you sleep. While charging overnight, your phone will automatically download any episodes from your loop recorder that were recorded during the day to send to your physician.
- If you experience symptoms such as dizziness, palpitations, fainting, or any other symptom that could be heart rhythm related, open the app on your phone as soon as you are able and press the "Record Symptoms" button to send your heart rhythm data to your doctor
- Keep your phone software up-to-date by either enabling automatic software updates, or manually update to new software as soon as it is available.
- For technical help, please call the Tech Support line at Abbott: 877-696-3754

X _____
Patient Signature

Date: _____ Time: _____