

Monitoring will not be initiated unless this form is completely filled out.

TELEMETRY REQUEST

Revised 12/00

Patient's Name: _____ Age: _____ Unit Number _____

Location: Floor _____ Room _____ Diagnosis: _____

Reason for monitoring: _____

Date to Begin: _____ Channel # _____

Private Patient-Attending _____ Ex./Phone _____ Beeper _____

Ward Patient-House Officer/Service _____ Beeper _____

Cardioactive Medications: _____

Patient's Basic Rhythm: _____

Prior known dysrhythmias: _____

Intervals: PR _____ QRS _____ QT _____

Pacer: Yes/No Mode _____ Rates: Low _____ High rate limit _____

AICD/ICD: Yes/No On/Off Rate cut off: VF _____ VT _____

Therapies: ATP _____ Defib _____ Backup pacing: Yes/No Mode: _____

Settings requested for alarms (Responsible MD to be Notified)

Heart Rates: High Limit _____ Low Limit _____

PHYSICIAN NOTIFICATION

VT (8 consc PVCs HR 120 or >) Yes _____ No _____ Bigeminy Yes _____ No _____

V Run (8 consc PVCs HR 100-120) Yes _____ No _____ Trigeminy Yes _____ No _____

V Salvo (4-7 consc PVCs HR > 100) Yes _____ No _____ _____

Triplets Yes _____ No _____ _____

Couplets Yes _____ No _____ _____

Pause (>3 sec) Yes _____ No _____ _____

Pacer not capturing Yes _____ No _____ _____

Channel #: _____ Name: _____
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Location: Floor

Room