Congenital Heart Defect Information Sheet

Name: _____

Address: _____

Date of Birth: _____ Phone: _____

Email:_____

Cardiologist:_____

Phone: _____

Hospital: _____

Phone: _____

Allergies

_____

_____

Diagnosis

1) _____

2) _____

3) _____

Other:

_____

Surgery and Catheterizations Date

1) _____ _____

2) _____ _____

3) _____ _____

Other:

_____

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Congenital Heart Defect Information Sheet

Devices	Date Inserted

Medications

NAME	DOSE	FREQUENCY

☐ **Congenital heart defect. Type:** _____

☐ **History of rhythm abnormalities – see diagnosis/EKG**

☐ **AICD** ☐ **Pacemaker** ☐ **Artificial valve(s)**

☐ **Anticoagulated using:** _____ **Target INR:** _____

☐ **Risk of stroke** ☐ **History of stroke**

☐ **Risk of subacute bacterial endocarditis (SBE)** ☐ **History of SBE**

☐ **Abnormal blood flow to ___left _____right arm**
(Blood pressure/pulse will be absent or diminished)

☐ **Persistent R to L shunt, IV air filters recommended**

☐ **Typical hemoglobin/hematocrit:** _____

☐ **Typical O2 saturation at rest:** _____

Congenital Heart Defect Information Sheet

In Emergency PLEASE CONTACT:

Name: _____

Relationship: _____

Home Phone: _____ Work Phone: _____

Please transport to the following hospital if possible:

Name: _____

Address: _____