Patient Consent for
Implantable Cardioverter Defibrillator (ICD) Deactivation

(must be reviewed with and signed by patient/parent/legal guardian/temporary substitute decision maker* prior to deactivation)

Section 1: Physician Discussion
I have discussed the following with the patient/family/parent/legal guardian or temporary substitute decision maker who, in my opinion understands the information provided

- Turning off the ICD will not cause death
- In the event of a dangerous rapid heart rate turning off the ICD will no longer provide a potentially lifesaving therapy such as electric shock and anti-tachycardia pacing
- Turning off the device will not be painful, nor will its failure to function cause pain
- Turning off the ICD lifesaving therapy function does not turn off the pacemaker function
- Patient can change their mind and have the ICD lifesaving therapy turned back on
- Shocks at end of life can cause a painful death
- There is a plan of care to ensure healthcare professionals contact information is available to the patient if they have new questions or concerns

Section 2: Patient or Substitute Decision Maker Consent
I ____________________________ (Circle: Patient / parent / legal guardian / temporary substitute decision maker name) having been given the full details of the consequences by Dr ____________________________ agree to the turning off the lifesaving therapy of (pts name) ____________________________ Implantable Cardioverter Defibrillator (ICD). I understand I can change my mind and request the ICD’s lifesaving therapy to be turned back on.

Signed (by patient/ parent / legal guardian / temporary substitute decision maker*) ____________________________
Date __________

*if signed by a temporary substitute decision maker, complete the confirmation of Substitute Decision Maker form.

Signature of physician: ____________________________ Date: __________ Time: __________

Section 3: Telephone Consent
I have discussed the points in section 1 and expected effects of ICD deactivation with (print name) ____________________________ who is the patient’s (state relationship) ____________________________ and who has given verbal consent as substitute decision maker

Physicians name: ____________________________ Signature ____________________________ Date (dd/mm/yyyy) __________

Section 4: Interpreter Declaration
I have accurately translated this document and acted as interpreter for the (circle: patient / parent / legal guardian / temporary substitute decision maker) who told me that he/she understands the explanation and consents as described above

Interpreter name (print) ____________________________ Signature ____________________________ Date __________

Note: Where possible, at the earliest opportunity, the person who granted consent over the phone should sign Section 2 of this form