

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:

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: _____

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In Emergency PLEASE CONTACT:

Name: _____

Relationship: _____

Home Phone: _____ Work Phone: _____

Please transport to the following hospital if possible:

Name: _____

Address: _____