**Record of decision and consent to withdrawal of shock therapy in a patient with an Implantable Cardioverter Defibrillator (ICD)**

Attach Patient Identification Sticker

Current location of patient:

………………………………

As a health care professional caring for the above patient I have discussed with the patient and/or their significant others that (**please tick**):

□ The device will no longer provide shock therapy in the event of a ventricular arrhythmia.

□ ICD deactivation will not cause imminent death.

□ ICD deactivation will be carried out non-invasively with an ICD programmer and that it is not painful.

**…………………………………………………………………………………………**

□ I am satisfied that I have obtained the patient’s informed consent to withdraw ICD shock therapy

**or**

□ I am satisfied that the patient lacks capacity to consent to withdraw from treatment and believe it is the patient’s best interests that ICD therapy should be withdrawn. I have taken into account the relevant view and wishes of those close to the patient and the views of the multidisciplinary team

□ I have informed the cardiac physiologists and/or cardiac specialist nurse at SDH.

Name:………………………………………Consultant

Signature…………………………………..Date:……………………………………

**To be completed by a cardiac physiologist:**

Date and time device deactivated:………………………………………………….

Signature of cardiac physiologist:……………………. Print name:……………..

**This completed form should be filed in the patient’s medical notes and ICD notes.**