TTM INFORMATION SHEET

1. This is _____ (Your Name) calling for _____ (Patient's Name if sent by someone else) (please spell last name)

   Today is _____ (Date) . Local time is _____ (Time).

   I am calling from _____ (City, State, Country) . My phone number is _____ (Date).

2 The serial number of my transmitter is _____ . (located on the side of transmitter)

3. My transmitter batteries are changed every _____ ☐ *hours* ☐ *days* ☐ *weeks*

4. My pacing schedule is _____ ☐ *hours* ☐ *minutes* per ☐ *day* ☐ *night*

   on the ☐ *left* ☐ *right* ☐ *both* sides.

5. When on the pacer, breathing is ☐ *adequate* ☐ *not adequate*

   (If inadequate, please describe any symptoms)

6. The diaphragm pacing equipment ☐ *is* ☐ *is not* working properly.

   (If you feel something is wrong, please describe)

7. There ☐ *is* ☐ *is not* any pain and/or discomfort during stimulation.

   (if yes, please describe location and sensation)

8. There ☐ *is* ☐ *is not* any swelling, redness, or pain near any of the implanted components.

   (if yes, please describe location and condition)

9. Since the last TTM, the dials on the transmitter ☐ *have* ☐ *have not* been adjusted

   (If yes, please state reason for the adjustment and who performed the adjustment)

   The amplitude settings are _____ on the left side and _____ on the right side.

Please provide as much of the following information as possible

10. My tidal volume is _____ on the left side, _____ on the right side, and _____ on both sides.

    My blood pressure is _____ over _____. My temperature is _____ ☐ °F ☐ °C

    I ☐ have ☐ have not had any headaches recently. (If yes, please state how often and at what times)

    My CO_2 level is:_____ . My O_2 level is: _____ .

    My lips, fingernail, and face coloring is: ☐ *normal* ☐ *abnormal*. (If abnormal, please decribe)

    My bowels and bladder function are: ☐ *normal* ☐ *abnormal*. (If abnormal, please describe)

11. My last visit with a physician was with Dr. _____ on _____ .

12. Please send the results of this TTM to Dr. _____ .

    Phone Number: _____ Fax Number: _____