

Patient Name: [Insert Name]

Date of Birth: [Insert DOB]

Hospital Number: [Insert ID]

Date of Procedure: [Insert Date]

Discharge Summary: DC Cardioversion

Procedure Performed: Direct Current Cardioversion (DCCV)

Indication: Persistent Atrial Fibrillation / Atrial Flutter

Procedure Details:

- Pre-procedure Rhythm: [Atrial Fibrillation / Atrial Flutter]
- Number of Shocks: [Insert Number]
- Energy Level (Joules): [Insert Joules]
- Post-procedure Rhythm: [Sinus Rhythm / Atrial Fibrillation / Other]

Complications: [None / Specify if any]

Anticoagulation Plan:

The patient must continue taking [Insert Medication Name] for at least 4 weeks post-procedure. Do not stop this medication unless instructed by a cardiologist.

Medication Changes:

- [Medication Name]: [Start / Stop / Continue at Dose]
- [Medication Name]: [Start / Stop / Continue at Dose]

Follow-up Instructions:

- Repeat ECG in [Insert Timeframe].
- Outpatient Cardiology Clinic appointment in [Insert Timeframe].
- Contact the clinic if you experience palpitations, chest pain, or shortness of breath.

Discharging Clinician: [Insert Name/Title]

Signature: _____