Heart Rhythm Referral Form *(2 pages)*
Electrophysiology Study and Ablation

FAX 416-340-5338

Referral Date: _____ **Patients Name:** _____

Referring Physician: _____ **MRN** _____ **DOB** _____

Health Card Number_____

□ Emergent (while in hospital)
□ Urgent (3-5 days)
□ Semi-Urgent (1-2 wks)
□ Elective
□ In-Pt Pending discharge:
□ In-Pt Location _____
□ Caution _____

Height: _____cm
Weight: _____ kg

Wait Location: _____

Indicate Hospital name OR select a location
□ Home □ Rehab Facility □ Outside of Province □ Outside of Country

Race: Race is self-identified by the patient. Patient may identify as one or more option			
□ Black	□ East/Southeast Asian	□ Indigenous (First Nations, Métis, Inuk/Inuit)	□ Latino
□ Middle Eastern	□ South Asian	□ White	□ Other
The following options cannot be indicated with any other option:		□ Unknown □ Prefer Not to Answer	□ Not Collected

Procedure Requested	□ Diagnostic Study				
	□ Standard Ablation	□ AV Node Ablation	□ AVRT/WPW	□ SVT/AVNRT	□ Atrial Flutter
	□ Complex Ablation	□ Ventricular Tachycardia	□ Atrial Tachycardia	□ Atrial Fibrillation □ Persistent □ Paroxysmal	□ Right Heart Cath
		□ Cryoablation	□ Cartoablation	□ Velocity	□ Other please specify: _____

Reasons for Referral: Primary reason for the patient's referral is required. Select the appropriate reason by circling P to indicate one Primary Reason for Referral, and S, if applicable, to indicate one Secondary Reason for Referral.

Arrhythmia:	**Coronary Disease:**
P S Atrial Flutter	S Stable Angina (or Equivalent)
P S Atypical Atrial Flutter	S Unstable Angina (or Equivalent)
P S Atrioventricular Nodal Re-entrant Tachycardia (AVNRT)	S Non-ST-Segment Elevation Myocardial Infarction (NSTEM)
P S Atrial Tachycardia	S ST-Segment Elevation Myocardial Infarction (STEMI)
P S Paroxysmal Atrial Fibrillation	**Valve Disease:**
P S Persistent Atrial Fibrillation	S Aortic Stenosis
P S Ventricular Fibrillation	S Aortic Regurgitation
P S Ventricular Tachycardia	S Other Valvular
P S Wolff-Parkinson-White Syndrome	S **Cardiomyopathy**
Other:	S **Congenital/Structural**
P S Heart Disease of Other Etiology	S **Heart Failure**
P S Protocol (Research/Employment)	**Heart Transplant:**
P S Syncope	S Donor
	S Recipient

Additional Notes: Clinical Status Update (include date) _____

_____

_____

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Patient's Name: _____

MRN _____

Health Card Number _____

Diagnostic Information:
LA Diameter _____mm Method □ Echo
LV Function _____% Method □ Muga □ Echo □ Other □ Not done
Left Ventricular Ejection Fraction _____ % □ Grade 1 □ Grade 2 □ Grade 3 □ Grade 4 □ Not done

Antiplatelet/Anticoagulation:	**Anticoagulation Reasons:**
□ None	□ A Fib/Flutter
□ ASA	□ Previous Stroke
□ Plavix	□ Mechanical Valve(s)
□ Dabigatran (Pradaxa)	□ Bioprosthetic Valve (s)
□ Rivaroxaban (Xarelto)	□ LA/LV thrombus
□ Apixaban (Eliquis)	□ LVAD
□ Edoxaban	□ CVA
□ LMWH	□ TIA
□ Coumadin	□ Post PCI
□ Heparin	
□ Other	

Medications	
□ Antiarrhythmic	Additional Notes: Clinical Status Update (include date) _____
□ Beta Blocker	_____
□ Amiodarone	_____
□ Anti-platelet	
□ ARB's	
□ Ca Channel Blocker	
□ Diuretic	
□ Ace Inhibitor	

Accepting Physician:_____**Accepting Date**:_____**Procedure Date:**_____

Fax Referral & Supporting Documents: Recent 12 lead ECG, Consult, History and Physical, Cardiac Echo, List of Medications/ dosages, Device Info/Interrogation List of Medications/ dosages, Device Info/Interrogation