Trillium Health Partners

ARRHYTHMIA SERVICE REFERRAL FORM

Ph: 905 848-7580 x 2903 Fax: 905 804-7736

Dr. C. Le Feuvre / Dr. M. Platonov/ Dr. A. Ha

PLEASE FAX COMPLETED REFERRAL PACKAGE TO: 905-804-7736

Name _____
Last Name First Name Mid Initial

☐ Male ☐ Female DOB: _____
DD/MM/YYYY

Ontario Health #: _____

MRN/Unit # _____
Address: _____
Postal Code: _____
Phone Number: ( ) _____

Referring Information:

Referring MD Name: _____ Date of Referral: _____

Referring MD Signature: _____ Phone #: _____

Patient Location: ☐ Home ☐ Hospital _____ Unit _____

Reason/Diagnosis for Referral:
☐ **Assessment** ☐ **EP Study** ☐ **BIV/CRT (LVEF ≤35%, QRS >140 ms LBBB or IVCD)**
☐ **Pacemaker** ☐ **Ablation** ☐ **ICD (LVEF ≤30% by MUGA or quantitative ECHO)**
☐ **ILR** ☐ **Cryoablation** (AF) ☐ **SubQ ICD (age < 55, no CRT or brady pacing indication)**
☐ **Device at ERI** ☐ **VT ablation** (ischemic or non-ischemic cardiomyopathy)

Arrhythmia/Syndromes (check all that apply)

☐ Sustained VT ☐ SVT ☐ Trifascicular Block
☐ VF ☐ Atrial Fib ☐ Advanced AV Block
☐ Cardiac Arrest ☐ Atrial Flutter ☐ Other _____
☐ Syncope/Presyncope ☐ Frequent PVC/PAC ☐ Tachy/Brady Syndrome
☐ Long QT ☐ Sinus Bradycardia/Pause
☐ Brugada Syndrome Longest Pause _____ sec
☐ ARVD
☐ Family Hx of Sudden Death
☐ **Hx of CHF** ☐ **Post-MI**
EF _____ **%** **NYHA** _____

CLINICAL INFORMATION:

☐ **Diabetes** ☐ **TIA/CVA** ☐ **COPD** ☐ **Renal Dysfunction** ☐ **On Dialysis** ☐ **Obesity (>250 lbs)**
☐ **Vascular Access Issues (i.e. prior radiation/prior port-a-cath/AV fistula)** _____
☐ **Other significant health information:** _____
Pacemaker/ICD? ☐ **No** ☐ **Permanent** ☐ **Temporary Site:** _____ **Date:** _____
Anticoagulants: ☐ **No** ☐ **ASA/Clopidogrel/Ticagrelorq Heparin/LMWH** ☐ **Warfarin** ☐ **Novel Anticoagulant**
Allergies? ☐ **NKA** ☐ **Yes** _____
Dominant Hand ☐ **Left** ☐ **Right**
Is patient cognitive to sign consent? ☐ **Yes** ☐ **No** **If no, has family/POA been informed?** ☐ **Yes** ☐ **No**
COMMENTS: _____

SUPPORTING DOCUMENTS:

PLEASE INCLUDE THE FOLLOWING DOCUMENTS WITH THIS REFERRAL FORM IF AVAILABLE AND RELEVANT:

☐ **Consult Notes** ☐ **Holter** ☐ **Nuclear Perfusion Scan**
☐ **Medication list** ☐ **ECHO** ☐ **Cardiac Catheterization**
☐ **Recent labs** ☐ **MUGA (must be included Primary ICD)** ☐ **ECG, Telemetry Strips**

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