Ontario Health
CorHealth Ontario

Trillium Health Partners
Better Together

Arrhythmia Service Referral Form

PHONE 905 848-7193
FAX TO 905-804-7736

Instructions: Send to Regional Cardiac Centre directly. Do NOT send to CorHealth Ontario. Select only one option, unless noted otherwise.

Patient Information

First Name:	**Middle Name:**	**Last Name:**	
Health Card Number: Auth. Issuing:	**DOB:** YYYY-MM-DD	**MRN:**	
Street Address:	**Suite:**	**City:**	**Prov./State:**
Postal/Zip Code:	**Country:** If outside Canada	**Primary Phone:**	**Alternate Phone:**

Language of Preference:

Referral Information

Referring Physician: Name and/or CPSO Number	**Referring to Physician:** Leave blank if no physician preference
Referring Physician Phone:	**Referring Physician Fax:**

Wait Location: Indicate Hospital name OR select a location

☐ Home ☐ Hospital: _____ ☐ CCU/ICU ☐ Ward: _____ ☐ ER

Procedure Required

EP Studies & Ablations: ☐ Electrophysiology Study ☐ Standard Ablation ☐ Complex Ablation

ICD & Pacemaker:
☐ Single Chamber Implantable Cardioverter Defibrillator ☐ Dual Chamber Implantable Cardioverter Defibrillator
☐ Cardiac Resynchronization Therapy Implantable Cardioverter Defibrillator ☐ Cardiac Resynchronization Therapy Pacemaker
☐ Pacemaker ☐ ILR ☐ Cardioversion

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

Arrhythmia:

Advanced AV Block	Paroxysmal Atrial Fibrillation	Trifascicular Block
Atrial Flutter	Persistent Atrial Fibrillation	Ventricular Fibrillation
Atypical Atrial Flutter	Sinus Bradycardia/Pause – Longest Pause ____ sec	Ventricular Tachycardia
Atrioventricular Nodal Re-entrant Tachycardia (AVNRT)	SVT	Wolff-Parkinson-White Syndrome
Atrial Tachycardia	Tachy/Brady Syndrome	Other _____

Other:
- Heart Disease of Other Etiology
- Protocol (Research/Employment)
- Syncope
- **Cardiomyopathy**
- **Heart Failure**

Coronary Disease:
- ☐ Stable Angina (or Equivalent)
- ☐ Unstable Angina (or Equivalent)
- ☐ NSTEMI
- ☐ STEMI
- ☐ **Congenital/Structural**

Valve Disease:
- ☐ Aortic Stenosis
- ☐ Aortic Regurgitation
- ☐ Other Valvular _____

Heart Transplant:
☐ Donor ☐ Recipient

Comorbidity Assessment:

Anticoagulant:
☐ Apixaban (Eliquis) ☐ Rivaroxaban (Xarelto)
☐ Dabigatran (Pradaxa) ☐ Warfarin (Coumadin)
☐ Edoxaban/Lixiana ☐ Other

Antiplatelets:
☐ ASA ☐ Ticagrelor (Brilinta)
☐ Clopidogrel (Plavix)

☐ **Renal Disease**
☐ Dialysis

☐ **Diabetic**
☐ Oral
☐ Insulin
☐ Diet

☐ **Dye Allergy**
☐ Other Allergy
_____

Additional Notes:

Diagnostic Information

Heart Failure Class (NYHA): ☐ I ☐ II ☐ III ☐ IV ☐ N/A

Left Ventricular Ejection Fraction: Only required for ablation referrals, indicate either a percentage or a grade
_____ % ☐ Grade 1 ☐ Grade 2 ☐ Grade 3 ☐ Grade 4 ☐ Not Done

Height: _____ cm **Weight:** _____ kg

History of Congestive Heart Failure: ☐ Yes ☐ No

Implant Status: ☐ New ☐ Replacement ☐ Upgrade

Device Indication: Not required for CRT Pacemaker referrals
☐ Primary Prevention ☐ Secondary Prevention

Referring Physician Signature:

Date: YYYY-MM-DD

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

☐ Consult Notes ☐ Medication List ☐ Recent Labs ☐ Holter ☐ ECHO ☐ Cardiac Catheterization