CARDIAC CARE NETWORK
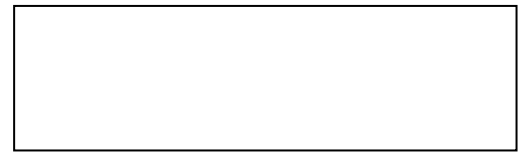
Heart Rhythm Referral Form

Date of Referral: _____

Referring Physician _____ **Requested Procedural Physician**_____ □ or First available

Phone_____ -_____-_____

Fax _____ -_____-_____

Patient Location

□Elective

□Emergent (while in hospital)   PT hospital location: _____

□Semi-Urgent (within 2weeks)

Reason for Referral □ EP Consultation Only   □ New VVI- ICD □ New DDD-ICD □ New CRT-D □ New CRT-Pacemaker □ Loop Recorder

□ Replacement Device Indicate type _____   □ Upgrade Device *(Includes PM to ICD or CRT)*

ICD/CRT Device Indication: □ Primary   □ Secondary

□ **ICD**   □ Ischemic CM □ Non-Ischemic CM □ Inherited Arrhythmia Syndrome

□ **CRT-D**   NYHA_____ QRS_____ms (per most recent ECG)
□ **CRT-P**   NYHA_____ QRS_____ ms (per most recent ECG)

□ **Implantable Loop recorder**
□ **Lead ONLY** (Type) _____□ Insertion   □ Revision □ Replacement □ Extraction
□ **DFT** Testing (ICD, CRT-D)

Ablation/ Diagnostic Study

** Bold elements in red MANDATORY for Atrial Fibrillation**

□ Diagnostic Study   □ **Atrial Fibrillation** □ **Persistent**   □**Paroxysmal**

□ Atrial Flutter   □ AVNRT   □ AV Node Ablation □ AVRT/WPW   □ Ventricular Tachycardia
□ Other please specify _____

Co morbidities

LA diameter_____mm   **Method Obtained:**   □ ECHO   □ Cardiac CT □ Unknown

Ejection Fraction Method _____% Date _____   **Medications**

Syncope	□ Yes (date) _____□ No	□ Antiarrhythmic
Cardiac Arrest	□ Yes (date) _____□ No	□ Beta Blockers
History of MI	□ Yes (date) _____ □ No	□ Amiodarone
Previous CABG	□ Yes (date) _____□ No	□ Anti-Platelet
Previous PCI	□ Yes (date) _____ □ No	□ ARB's
□ Hyperlipidemia	□ **Hypertension**	□ Ca Channel Blockers
□ Renal Disease	□ **Heart Failure**	□ Ace Inhibitors
□ **Anticoagulant (type)** _____	□ **Diabetes**	□ Diuretics
□ **Prior CVA/TIA/Thromboembolism**	□ **Vascular Disease**	
□ **COPD**	□ Creatinine _____µmol/L	

Acceptance Date (completed by procedural physician) _____

Fax Referral and Supporting Documents to Service Location/Physician (Include Recent 12 lead ECG, Consult, Hx and Physical, Cardiac Echo, List of Meds/dosages, Device interrogation if applicable) **For an updated list of Fax numbers** please see: Regional Cardiac Care Coordinators contact list located at: http://www.ccn.on.ca/ccn_public/FormsHealthCareProvider/resourcesforms.aspx