St.Mary's REGIONAL CARDIAC CARE CENTRE

ICD & CRT REFERRAL FORM

REFERRING PHYSICIAN INFORMATION

Name		Referral Date		Referral Type	☐ Primary ☐ Secondary ☐ Re-referral
Name of Institution		Contact Information (phone, email, fax)			

PATIENT INFORMATION

Name		Address			
Contact Information (phone, email, fax)		DOB / /		Gender	☐ Male ☐ Female
Current Patient Status: ☐ Inpatient ☐ Outpatient		OHIP No. and Version code:			

PLEASE SELECT THE APPROPRIATE BOXES

	PLEASE SELECT THE APPROPRIATE BOXES	COMMENTS
☐ ☐ ☐	Non-ischemic cardiomyopathy for a minimum of 9 months and Optimal Rx Ischemic cardiomyopathy and a minimum of 3 months post coronary revascularization, CABG etc. DATE of Most Recent Myocardial Infarction: ____________________	
☐ ☐	LVEF ≤ 30% - determined while patient was stable and after 3 months on Optimal Rx MUGA - DATE: ______________________ EF Result: ________________ Echo - DATE: ______________________ EF Result: ________________	
☐	NYHA Class Determined: ☐ NYHA Class 1 ☐ NYHA Class 2 ☐ NYHA Class 3 ☐ NYHA Class 4	
☐	Documented Congestive Heart Failure for a period of > 6 months	
☐	Documented sustained VT or cardiac arrest due to VF	
☐	Adequate doses of medications for a period of > 3 months: ☐ Carvedilol ☐ Bisoprolol ☐ Metoprolol ☐ ACE-I ☐ ARB ☐ Other: ________________ ☐ Lasix ☐ Spironolactone	
☐	QRS Duration: ________________ms	
☐	Discussion held with patient about ICD and patient is now aware of this referral	

PLEASE SELECT YES OR NO

Yes	No		COMMENTS
☐	☐	Atrial fibrillation? If yes, ☐ Permanent or Persistent (> 6 months) ☐ Paroxysmal Oral anticoagulants: ☐ Warfarin (Coumadin) ☐ Other ________________ ☐ ASA	
☐	☐	Prosthetic Heart Valve or Structural Valvular Disease	
☐	☐	Diabetes Mellitus? If yes, Diabetes Control: ☐ None ☐ Diet ☐ Oral Agent ☐ Insulin ☐ Unknown	
☐ ☐ ☐	☐ ☐ ☐	Symptomatic Bradycardia Hypertension Cognitive Impairment	
☐	☐	Hx of CVA/TIA? If yes, disability level: ☐ Recovered ☐ Minor Persisting Disability ☐ Major Persisting Disability	
☐	☐	Chronic obstructive lung disease?	
☐	☐	History of Drug/ETOH, major psych illness? If Yes, current Drug/ETOH, major psych illness: ____________________	
☐	☐	History of Cancer? If yes, ☐ Inactive cancer (cured in remission) ☐ Active cancer	
☐	☐	Patient on dialysis or chronic renal failure? If applicable, most recent serum creatinine: ____________________	

IMPORTANT! PLEASE ATTACH:

☐ Recent Consult ☐ MUGH/ECHO results ☐ ECG results ☐ Cardiac Catheterization results
☐ Other: ___________________

PLEASE FAX COMPLETE FORM TO: ARRYHTHMIA SERVICE 519-749-6589