St.Mary's
REGIONAL CARDIAC CARE CENTRE

HEART RHYTHM REFERRAL FORM

HEART RHYTHM COORDINATOR Ph: (519) 749-6578 Ext 1500

FAX COMPLETED REFERRAL TO (519) 749-6589

PATIENT INFORMATION:

Current Patient Status: ☐ Out patient ☐ In patient at Unit

Name:	HCN :
DOB:	Phone:

Address:

REFERRING PHYSICIAN INFORMATION :

Name: Specialty:	Phone : Fax:	Other Physicians Involved in Pt's Care:

REASON FOR REFERRAL:

☐ PACEMAKER / CRT-P / IMPLANTABLE LOOP RECORDER

☐ DEFIBRILLATOR / CRT-D (Discussion held with patient & patient aware of this referral)

☐ CATHETER ABLATION (Discussion held with patient & patient aware of this referral)

☐ SVT ☐ Atrial Flutter ☐ Atrial Fibrillation

☐ OTHER REASON FOR ARRHYTHMIA CLINIC:

Please provide the reason for referral and brief history:

☐ Patient has a Cardiac Device

FAX THIS REFERRAL FORM ALONG WITH ALL OF THE FOLLOWING:

Please note: Referral will not be processed/reviewed by MD until it is complete

Blood Work – (Inpatients only) within 48 hours
CBC, Electrolytes, Glucose, BUN, Creatinine, INR

ECHO or other assessment of LV Function (MUGA)

Previous Cardiac Investigations (Cardiac Cath / Catheter Ablation)

12 Lead ECG / Telemetry strips / Holter strips showing **ABNORMAL** rhythm

Consult Note / History & Physical

Medication List