

ARRHYTHMIA CONSULT REFERRAL FORM
HEART RHYTHM PROGRAM (519) 749-6578 x1500

PLEASE FAX COMPLETE FORM TO: HEART RHYTHM PROGRAM 519-749-6589

REFERRING PHYSICIAN INFORMATION

Name (print)	Contact Information (phone)
Referral Date	(fax)

PATIENT INFORMATION

Name	Address		
Contact Information (phone), email, fax	DOB / /	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Contact Information (email, fax)			
Current Patient Status: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	OHIP No. and Version code:		

REASON FOR REFERRAL

PLEASE SELECT THE APPROPRIATE BOXES

COMMENTS

<input type="checkbox"/>	Please provide the reason for referral and how long it has persisted:	
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HISTORY:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	MI	<input type="checkbox"/>	<input type="checkbox"/>	Other structural heart disease
<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Syncope
<input type="checkbox"/>	<input type="checkbox"/>	LVEF <30%			
<input type="checkbox"/>	<input type="checkbox"/>	Other:			

FAX THIS REFERRAL FORM ALONG WITH THE FOLLOWING INFORMATION

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Blood Work – Inpatients within 24 hours, outpatients within one month <input type="checkbox"/> CBC <input type="checkbox"/> Electrolytes <input type="checkbox"/> BG <input type="checkbox"/> BUN <input type="checkbox"/> Creatinine <input type="checkbox"/> INR
<input type="checkbox"/>	<input type="checkbox"/>	ECHO or other assessment of LV function (cath, MUGA)
<input type="checkbox"/>	<input type="checkbox"/>	ECG
<input type="checkbox"/>	<input type="checkbox"/>	Telemetry strips showing abnormal rhythm
<input type="checkbox"/>	<input type="checkbox"/>	Consult note/admitting note
<input type="checkbox"/>	<input type="checkbox"/>	Medication list