SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Heart Rhythm Triage Office
Tel: (905) 895-4521 x 2572, Fax: (905) 830-5806

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Heart Rhythm Program Procedure Referral

❑ **OUT-PATIENT** ❑ **IN-PATIENT** Hospital Name: _____ Unit: _____ Contact #: _____

Patient Name: *(print first, last)*	**Date of Birth:** dd / mm / yy
Address: Street Number and Name Apartment City Province Postal Code	
Contact Number:	**Alternate Number:**
Health Card Number:	**Copies to:** ❑ Family Physician ❑ Other Doctor:
Referring Physician: *(print first, last)*	**Family Physician:** *(print first, last)*
Phone:	**Phone:**
Fax:	**Fax:**

Referral for: ❑ Office/Clinic Consultation ❑ Permanent Pacemaker ❑ Implantable Cardioverter-defibrillator ❑ Cardioversion ❑ Biventricular/Cardiac Resynchronization Therapy ❑ Implantable loop recorder ❑ Electrophysiology Study/Ablation

Comorbidity Assessment: Height: _____ cm Weight: _____ kg Creatinine Value: _____

YES	NO		YES	NO	
❑	❑	**Diabetes** – Treatment: _____	❑	❑	**CHF** – NYHA Class: 1 2 3 4
❑	❑	**Allergies:** ❑ Dye ❑ Latex Other: _____	❑	❑	**Vascular disease**
❑	❑	**Anti-coagulant:** ❑ Warfarin ❑ DOAC _____	❑	❑	**Valve replacement** – Location: _____
❑	❑	**Echo/MUGA** – EF _____ LA size ____mm			Type: ❑ Mechanical ❑ Bioprosthetic
❑	❑	**ECG** – QRS_____ms	❑	❑	**Stroke/TIA/Thromboembolism**
❑	❑	**Previous CABG** _____	❑	❑	**History of MI:** ❑ more than 3 months
❑	❑	**Previous PCI** _____			❑ less than 3 months
❑	❑	**Hypertension** _____	❑	❑	**Existing PPM/ICD** _____
❑	❑	**COPD** _____	❑	❑	**TTVP/Epicardial Leads** – Site: _____

THE FOLLOWING DOCUMENTATION MUST ACCOMPANY THE REFERRAL BEFORE A PLAN OF CARE CAN BE DETERMINED.

- 12 Lead ECG (need actual tracing not report)
- Echo report (full quantitative study)
- Full Holter/Loop/Telemetry reports **and** rhythm strips
- Consultation note including symptoms and medication list

Additional information: *(if available)*
❑ Recent labs ❑ Chest x-ray ❑ Cardiac MRI ❑ MUGA/MIBI ❑ Stress test ❑ Cardiac Catheterization/PCI notes

Comments:

PLEASE COMPLETE REFERRAL AND FAX WITH REQUIRED DIAGNOSTIC TESTING TO (905) 830-5806.
BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL.

Referring Physician Signature: **Date:** dd / mm / yy