ST. MICHAEL'S
UNITY HEALTH TORONTO

Kamran Ahmad MD, FRCPC
Paul Angaran MD, FRCPC
Paul Dorian MD, FRCPC
Karen Konieczny MD, FRCPC
Victoria Korley MD, FRCPC
Iqwal Mangat MD, FRCPC
Arnold Pinter MD
Jennifer Cruz RN(EC), MN, NP-Adult

30 Bond Street, Toronto, ON M5B 1W8 **Tel: (416) 864-6060 ext. 3177** **www.stmikesEP.com**

ATRIAL FIBRILLATION CLINIC REFERRAL FORM

Robert McRae Heart Health Unit – 7th Floor Donnelly Wing

Patient Information: (written or sticker)

Name:

DOB (m/d/y): **Age:** **Sex:** M / F

Address:

Telephone:

Medical History:
(check all applicable)

- ☐ CHF or LV dysfunction
- ☐ HTN
- ☐ Age ≥ 65 years
- ☐ Diabetes
- ☐ Stroke/ TIA

Date of Referral: _____

Reason for Referral:

- (circle one): Atrial Fibrillation / Atrial Flutter
- (circle one): Paroxysmal / Persistent / Permanent
- New Onset (circle one): Yes / No
- Recent ED visit (within 30 days): Yes / No If yes, which ED hospital?: _____
- Anticoagulation status (circle one): None / Aspirin / Clopidogrel / Warfarin / DOAC: _____
- Is the patient symptomatic? Yes / No If yes, specify: _____

Documents & Diagnostic Test results:

NOTE: Please attach as much of the following information as available to you and indicate which one(s) you are sending.

- ☐ Clinical information (typed notes)
- ☐ ECGs (ideally during arrhythmia)
- ☐ Holter monitor / Loop
- ☐ Echocardiogram
- ☐ Stress Test

Referring Physician (please print)**:** _____ **Billing #:** _____

Contact Information (telephone, pager or fax)**:** _____

Please send or fax information to: (416) 864 - 5348

Revised: July 20, 2020