ST. MICHAEL'S
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CARDIAC ARRHYTHMIA SERVICE 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:

- Recent ED visit (within 30 days): Yes / No
  If yes, which ED hospital?: _______________
- Is the patient symptomatic? Yes / No
  If yes, specify: ________________________

Date of Referral: ____________________

Reason for Referral:

- ☐ Ablation
- ☐ Atrial Flutter
- ☐ Atrial Fibrillation
- ☐ Atrial Tachycardia
- ☐ Electrical Cardioversion
- ☐ Electrophysiology Study
- ☐ Frequent PVCs
- ☐ ICD consideration
- ☐ ICD assessment & Transfer of device care
- ☐ Inherited Arrhythmia Syndrome
- ☐ Pacemaker consideration
- ☐ Palpitations
- ☐ PM assessment & Transfer of device care
- ☐ SVT/WPW
- ☐ Syncope
- ☐ Ventricular Tachycardia
- ☐ Ventricular Fibrillation
- ☐ Other: ______________________________

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
- ☐ Other: _______________

Referring Physician (please print): ______________________________ **Billing #:** _______________

Contact Information (telephone, pager or fax): ____

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

Revised: July 20, 2020