Alberta Health Services

Calgary Zone Cardiac Arrhythmia Referral

Ph. 403-944-4632
Fax 403-592-4241

Patient Name	
RHRN	DOB
HCN	Gender M ☐ F ☐
Address	Province
City/Town	Postal Code
Phone - Home	Work
Alternate Contact	
Date *(yyyy-Mon-dd)*	

Yes ↓ Is there **documentation of Arrhythmia?**

- Include documentation of all arrhythmias *(e.g. 12-lead ECG, Holter, rhythm strip)*

No ↓ Is this referral for an **in-patient?**

☐ Yes, **page or call (403-944-1110)** and ask for the electrophysiologist on call. **Do not send referral.**

No ↓ Has the patient been seen by an **electrophysiologist in the past?**

☐ Yes, patient has an electrophysiologist, Dr.__________________________.
Consider sending referral directly to existing electrophysiologist.

No ↓ Does patient require evaluation or **MEDICAL** management of **atrial fibrillation or flutter?**

☐ Yes, please send referral to **Atrial Fibrillation Clinic:**
Foothills Medical Centre fax 403-944-3580 or South Health Campus fax 403-956-2645

Requested Physician for consult:

Who: ______________________

Or ☐ 1st available physician

Reason for referral ***(check all that apply)***

Opinion for:

- ☐ Ablation
  - ☐ Atrial Fibrillation (AF)
  - ☐ Atrial Flutter (AFL)
  - ☐ Supraventricular Tachycardia (SVT)
  - ☐ Wolf Parkinson White (WPW)
  - ☐ Ventricular Tachycardia (VT)
- ☐ Left Atrial Appendage Occlusion device

Evaluation and Management of:

- ☐ Brugada Syndrome
- ☐ Long QT Syndrome
- ☐ Palpitations
- ☐ Premature Ventricular Contractions (PVC)
- ☐ SVT *– associated with Syncope* ☐ yes ☐ no
- ☐ Syncope
- ☐ Autonomic Dysfunction (IOH, IST, OH, POTS) Specify:______________________
- ☐ WPW *– associated with Syncope* ☐ yes ☐ no

*Please note - Syncope within the setting of any documented arrhythmia should be reported urgently.

Referring Physician:

Ph: Fax:

Family Physician:

Ph: Fax:

☐ No Current Family Physician

Mandatory Documents Required to Triage ***(please attach)***

All Arrhythmia Referrals:

- ☐ Baseline ECG
- ☐ Referral letter including history & med list
- ☐ Documentation of arrhythmia (AF,AFL,SVT,VT)

Syncope & Autonomic Dysfunction Referrals:

- ☐ Orthostatic Vital Signs (Heart Rate & Blood Pressure)
  Supine at 5mins
  Standing at 1 min, 3 mins, 5 mins, 8 mins, and 10 mins
- ☐ If diagnosed by Mayo, attach prior consult notes

Additional Cardiac Testing

Check all that are completed or pending AND attach all results

- ☐ Echocardiogram – date booked ____________________
  Where______________________________________
- ☐ Holter Monitor – date booked ____________________
  Where______________________________________
- ☐ Stress Test – date booked ______________________
  Where ______________________________________
- ☐ Other_______________________________________

Comments