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 403-668-2155

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