Alberta Health Services

Atrial Fibrillation Clinic Referral

Foothills Medical Centre Ph 403-944-3339
Fax 403-944-3580

South Health Campus Ph 403-956-2602
Fax 403-668-2155

Patient Name	
RHRN	DOB
HCN	Gender ☐ M ☐ F
Address	Province
City/Town	Postal Code
Phone - Home	Work
Alternate Contact	
Patient location ☐ Home ☐ Other	

Yes ↓

Is there **documentation of AF or atrial flutter?**

☐ I am including ECG documentation of AF or atrial flutter.
☐ I do not have ECG documentation of AF or atrial flutter.
ECG documentation must be included in order to process this referral.

No ↓

Does the patient have a **reversible cause of AF?**

e.g. significant electrolyte abnormality, thyrotoxicosis, sepsis *(e.g. pneumonia)*, drug or alcohol use

If so, *consider referral for appropriate management of the **reversible** condition before referral to AF Clinic.*

No ↓

Does the patient have access to a local Cardiologist?

☐ Yes, *name of MD* _____, *consider referral to existing Cardiologist rather than AF Clinic.*

Does the patient have a pacemaker or ICD?

☐ Yes, *consider referral to existing Cardiologist / EP at Cardiac Device Clinic.*

Referral details	**Patient details**
Referral date:	**Is patient currently in AF / AFL?** ☐ No ☐ Yes, resting HR:
Referral type: ☐ New ☐ Re-referral ☐ Second opinion	**Is patient currently in congestive heart failure?** ☐ No ☐ Yes, NYHA class:
Referral source ☐ Family Physician ☐ ER ☐ Other:	**Medical history** *(check all that apply)* ☐ Hypertension ☐ Pacemaker / ICD ☐ Diabetes mellitus ☐ CHF and/or LV dysfunction ☐ Prior stroke / TIA LVEF less than or equal to 40% ☐ Vascular disease ☐ Angina: CCS Class: (MI, PVD, aortic atheroma)
Referring Physician: Ph: Fax:	
Family Physician: Ph: Fax: ☐ does not currently have a Family Physician	
Reason for referral *(check all that apply)* ☐ Management plan ☐ Patient education ☐ Anticoag. assessment ☐ Cardioversion ☐ Other:	**Current antithrombotic therapy** *(check all that apply)* ☐ None ☐ ASA ☐ Warfarin ☐ DOAC *(e.g. dabigatran, apixaban, rivaroxaban, edoxaban)*
	Number of ER visits in last 3 months? ☐ None ☐ ____ visits, location:

Arrhythmia details	**Documentation** *(please attach the following)*
Arrhythmia type *(check all that apply)* ☐ Atrial fibrillation ☐ Atrial flutter ☐ New onset / new diagnosis ☐ Paroxysmal *(self-limiting less than / equal to 7 days)* ☐ Persistent *(greater than 7 days or requires cardioversion)* ☐ Longstanding persistent *(greater than 1 year continuous AF)* ☐ Permanent *(accepted AF/AFL, cardioversion failed or not done)*	******Documentation of AF/AFL is required****** ☐ ECGs (during AF/AFL ± SR) ☐ Patient history ☐ Full medication list **Cardiac testing** *(please attach full copies of all results)* ☐ Echo ☐ ETT ☐ Holter / event rec. ☐ MPI

Triage nurse to complete		
$CHADS_2$ score:	CHA_2DS_2-VASc score:	HAS-BLED score:
Priority: ☐ Urgent ☐ Semi-urgent ☐ Routine		Triage Date:
Notes:		