Alberta Health Services

Outpatient Cardiac Arrhythmia Referral

	Ph	Fax
Foothills Medical Centre	403-944-4632	403-944-5160
South Health Campus	403-956-2601	403-956-2645

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?**
- If available, 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)** 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:

Or ☐ 1st available physician

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

Opinion for:

☐ Ablation
- ☐ Atrial Fibrillation
- ☐ Atrial Flutter
- ☐ 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
☐ WPW – *associated with Syncope* ☐ yes ☐ no

South Health Campus Services:

☐ Implanted Loop Recorder
☐ Tilt Table Test *(additional referral form to fill in)*
☐ Cardioversion *(additional referral form to fill in)*
☐ Postural Orthostatic Tachycardia Syndrome (POTS)
☐ Autonomic Function Testing (AFT) *(additional referral form to fill in)*
☐ Other:

Referring Physician:
Ph Fax

Family Physician:
Ph Fax
☐ does not currently have a Family Physician

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

☐ Baseline ECG (MANDATORY)
☐ Referral letter including history (MANDATORY)
☐ Documentation of arrhythmia
☐ Medication list

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

Triage Nurse to Complete

Priority ☐ Urgent *(seen within 30 days)*
☐ Routine *(seen within 30-90 days)*

Notes