



Royal Victoria
Regional Health Centre

**Outpatient Pacemaker Follow Up Clinic
Cardiac Diagnostics**

201 Georgian Drive, Barrie, Ontario
Phone: 705-739-5604
Fax: 705-739-5651

PATIENT NAME: _____

DOB: _____

HRN: _____

(addressograph)

Patient Information

Patient Name: _____ Gender: _____
Address: _____ Postal Code: _____
Referring MD: _____ Family MD: _____ Physician Signature: _____

List the patient's home phone number, and if applicable, one alternate number. For each number, use the tick boxes to indicate if the patient consents to be called at that number and/or if messages relating to his/her care & appointments can be left at that number:

Home: Call – can leave a message on voicemail with a person

Work/Other: Call – can leave a message on voicemail with a person

Reason for Test (Mandatory)

Reason for Referral: Pre-Operative Radiation Other: _____

Please indicate urgency: 1 week 1 month 3 months 6 months 1 year

Device Type

Medtronic St.Jude Biotronik
 Ela/Sorin Boston Scientific

Single Chamber Pacemaker: _____ Dual Chamber Pacemaker: _____

Please note: RVH follows pacemaker devices only – no Implantable Cardioverter Defibrillator (ICD) or Cardiac Resynchronization Therapy (CRT)

New Device? Please advise if new software is required for this patient? _____

Is the patient followed by a Cardiologist? If yes, please list Cardiologist name: _____

This constitutes a referral for Cardiology consult within our Urgent Cardiology Clinic.

**** Please ensure implant notes, last follow up details, chest x-ray, echocardiogram and latest blood results are attached to this requisition ****

BY SIGNING THIS REQUISITION, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS TEST

Referring Physician: _____ Signature: _____ Date: _____
(Print)

Telephone Number: _____ Fax Number: _____ Billing # _____

