RVH
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 REQUISTION, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS TEST		
Referring Physician: (Print)	Signature:	Date:
Telephone Number:	Fax Number:	Billing #