RVH
Royal Victoria Regional Health Centre

Pacemaker Implant or Pack Change Referral Form
201 Georgian Drive, Barrie, Ontario
Coordinator: 705-817-6348
Fax: 705-797-3119

PATIENT NAME: _____

DOB: _____

HRN: _____

☐ **Outpatient** ☐ **In-Patient** Hospital Name: _____ Unit: _____ Contact #: _____

Referring Information

Patient Name: (print first, last): _____ Date of Birth: ____/____/_____

Address: _____

Contact Number: _____ Alternate Number: _____

Referring Physician: (print first, last): _____ Family Physician: (print first, last): _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Reason for Referral

☐ Assessment	☐Clinic Consultation	☐ Device at ERI (pack change)	☐ Pacemaker	☐ Conduction System Pacing	☐ Implantable Loop Recorder

Arrhythmia/Syndromes (check all that apply)

☐ Syncope/Presyncope	☐ Atrial Fibrillation	☐ Atrial Flutter
☐ Sick Sinus Syndrome	☐ Sinus Brady Pause	☐ Sinus Node Dysfunction
☐ Advanced AV Block	Longest Pause _____sec	☐ Other: Specify:_____

Clinical Information

Height: _____cm | Weight: _____kg | Creatinine Value: _____

Allergies: ☐ Dye ☐ Latex ☐Other (specify):_____ Type of Reaction: _____

Dominant Hand ☐ Left ☐ Right | Patient able to sign consent?☐ Yes ☐ No ☐ (if no, has family/POA been informed)

Anticoagulation ☐ No ☐ Warfarin ☐ ASA/Clopidogrel/Ticagrelor ☐ Heparin/ LMWH ☐ Novel anticoagulant

YES	NO		YES	NO	
☐	☐	Diabetes: ☐ Type I ☐ Type II	☐	☐	Heart Failure (circle one) – Class 1 2 3 4
☐	☐	CVA/TIA/Thromboembolism	☐	☐	COPD
☐	☐	Hypertension	☐	☐	Renal Dysfunction
☐	☐	Vascular disease	☐	☐	Previous PCI: _____
☐	☐	Previous CABG: _____	☐	☐	History of MI ☐ more than 3 months
☐	☐	Existing PPM/ICD: _____			☐ less than 3 months

Other significant health information: _____

THE FOLLOWING INFORMATION MUST ACCOMPANY THE REFERRAL (☒ checked boxed mandatory supporting documents)

☐ Consult Notes ☐ Recent labs ☐ Chest x-ray ☐ Medication list ☐ 12-ECG, (need actual tracing, not report)

☐ Echo Report ☐ Cardiac MRI ☐ Stress test ☐ PCI notes ☐ Full Holter/telemetry reports and rhythm strips

Comments:

PLEASE COMPLETE REFERRAL AND FAX WITH REQUIRED DIAGNOSTIC TESTING TO (705) 797-3119.

Referring Physicians Signature: _____ **Date:** _____/_____/_____