fraserhealth

Implantable Cardiac Electrical Devices
REFERRAL (PPM, ICD, CRT, CRT-P, CRT-D)
Cardiac Services Program

Fax: 604-520-4977 Confirm referral with: 1-855-529-7223
WEEKENDS and HOLIDAYS call cardiac surgeon on call via RCH switchboard: **604-520-4253**

Referral Date: _____ Diagnostic Code: _____ Class of Recommendation: _____

Patients Name (Last, First) _____

Date of Birth _____ PHN _____

☐ **INPATIENT** HOSPITAL _____ UNIT _____

☐ **OUTPATIENT** ADDRESS _____

City _____ Postal Code _____ Home No. _____ Other No. _____

Height: _____

Weight: _____

☐ Severe Obesity BMI >31

INDICATION: _____

PROCEDURE(S) REQUEST

☐ Permanent Pacemaker (**PPM**)
☐ Implantable Cardioverter Defibrillator (**ICD**) **or** ☐ Cardiac Resynchronization and Defibrillator **(CRT-D)**
☐ Cardiac Resynchronization Therapy (**CRT**) **or** ☐ Cardiac Resynchronization and Pacing **(CRT-P)**
☐ Epicardial LV Lead Placement
☐ Implantable Loop Recorder **(ILR)** ☐ IMPLANT **or** ☐ REMOVE
☐ Device Type: _____

☐ First Implant (**PPM** - device) ***Seen by Cardiologist**
☐ First Implant **(ICD/CRT** - device) ***Seen by Electrophysiologist**
☐ Repeat Procedure **Date of Last Implant (dd/mm/yy):** _____

☐ Generator replacement ☐ Pocket Revision ☐ Ileofemoral approach
☐ Lead revision/replacement ☐ Upgrade
☐ Reposition Device ☐ Right Side

URGENCY

PPM	☐ Urgent/Semi urgent inpatient **with** temporary transvenous pacemaker - immediate to 48 hours ☐ Urgent/Semi urgent impatient with **no** temporary transvenous pacemaker - 48 hours ☐ Outpatient (new implant or generator/lead change with **high risk** of syncope) - 2 weeks ☐ Outpatient (new implant or generator/lead change with **low risk** of syncope) - 6 weeks
ICD, CRT-D	☐ Secondary prevention - immediate to 3 days ☐ Primary prevention - 8 weeks
CRT, CRT-P	☐ **(Non-defibrillator)** CRT devices - 6 weeks

☐ **PATIENT IS PACEMAKER-DEPENDENT (Either temporary or permanent)**

- **Recent ECG faxed with referral**
- NYHA Class of Failure ☐ I ☐ II ☐ III ☐ IV
- CCS Class of Angina ☐ I ☐ II ☐ III ☐ IV
- LV Ejection Fraction _____ % Date: _____

MEDICATIONS

☐ **Warfarin**
- Date & INR: _____
- Last Dose: _____

Other blood thinners or drug infusions:

Specify: _____

Referring Physician: _____ **Family Physician:** _____

Referring Phone No: _____ **Pacemaker Follow-up:** _____