



fraserhealth

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



CDXX104964B

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**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**

<b>Referral Date:</b> _____ <b>Diagnostic Code:</b> _____ <b>Class of Recommendation:</b> _____	
Patients Name (Last, First) _____	<b>Height:</b> _____
Date of Birth _____ PHN _____	<b>Weight:</b> _____
<input type="checkbox"/> <b>INPATIENT</b> HOSPITAL _____ UNIT _____	<input type="checkbox"/> Severe Obesity BMI >31
<input type="checkbox"/> <b>OUTPATIENT</b> ADDRESS _____	
City _____ Postal Code _____ Home No. _____ Other No. _____	

## INDICATION:

PROCEDURE(S) REQUEST	
<input type="checkbox"/> Permanent Pacemaker (PPM) <input type="checkbox"/> Implantable Cardioverter Defibrillator (ICD) <b>or</b> <input type="checkbox"/> Cardiac Resynchronization and Defibrillator (CRT-D) <input type="checkbox"/> Cardiac Resynchronization Therapy (CRT) <b>or</b> <input type="checkbox"/> Cardiac Resynchronization and Pacing (CRT-P) <input type="checkbox"/> Epicardial LV Lead Placement <input type="checkbox"/> Implantable Loop Recorder (ILR) <input type="checkbox"/> IMPLANT <b>or</b> <input type="checkbox"/> REMOVE <input type="checkbox"/> Device Type: _____	
<input type="checkbox"/> First Implant (PPM - device) *Seen by Cardiologist <input type="checkbox"/> First Implant (ICD/CRT - device) *Seen by Electrophysiologist <input type="checkbox"/> Repeat Procedure <b>Date of Last Implant (dd/mm/yy):</b> _____	
<input type="checkbox"/> Generator replacement <input type="checkbox"/> Pocket Revision <input type="checkbox"/> Ileo femoral approach <input type="checkbox"/> Lead revision/replacement <input type="checkbox"/> Upgrade <input type="checkbox"/> Reposition Device <input type="checkbox"/> Right Side	
URGENCY	
<b>PPM</b>	<input type="checkbox"/> Urgent/Semi urgent inpatient <b>with</b> temporary transvenous pacemaker - immediate to 48 hours <input type="checkbox"/> Urgent/Semi urgent inpatient with <b>no</b> temporary transvenous pacemaker - 48 hours <input type="checkbox"/> Outpatient (new implant or generator/lead change with <b>high risk</b> of syncope) - 2 weeks <input type="checkbox"/> Outpatient (new implant or generator/lead change with <b>low risk</b> of syncope) - 6 weeks
<b>ICD, CRT-D</b>	<input type="checkbox"/> Secondary prevention - immediate to 3 days <input type="checkbox"/> Primary prevention - 8 weeks
<b>CRT, CRT-P</b>	<input type="checkbox"/> <b>(Non-defibrillator)</b> CRT devices - 6 weeks
<input type="checkbox"/> <b>PATIENT IS PACEMAKER-DEPENDENT (Either temporary or permanent)</b> <ul style="list-style-type: none"> <li>Recent ECG faxed with referral</li> <li>NYHA Class of Failure <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV</li> <li>CCS Class of Angina <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV</li> <li>LV Ejection Fraction _____ % Date: _____</li> </ul>	
MEDICATIONS	
<input type="checkbox"/> <b>Warfarin</b> <ul style="list-style-type: none"> <li>Date &amp; INR: _____</li> <li>Last Dose: _____</li> </ul>	<b>Other blood thinners or drug infusions:</b> Specify: _____
<b>Referring Physician:</b> _____	<b>Family Physician:</b> _____
<b>Referring Phone No:</b> _____	<b>Pacemaker Follow-up:</b> _____