fraserhealth

REFERRAL FORM
RCH Atrial Fibrillation Clinic

MSXX104070B Rev: Oct 29/10 Page: 1 of 1

PHONE: 604-528-5073 FAX: 604-528-5067 Number of pages (including this one) _____

PLEASE NOTE: Incomplete referrals will be **returned unprocessed ECG documentation of rhythm must be included**

Date: _____

Name of Patient:	PHN:	DOB:	Gender:
Address:		Postal Code:	
Home Phone:	Alternate Phone:		

Referring physician/NP: _____

Referred from: ❒ Primary care ❒ ED ❒ Internist ❒ Cardiologist

Primary Care Provider: _____

Purpose of referral *(Check one)*:
- ❒ Opinion
- ❒ Consultation
- ❒ Consultation and management
- ❒ Other: _____

AF diagnosis *(Check one)*:
- ❒ Recent/new diagnosis
- ❒ Previous diagnosis

Assistance with *(Check all that apply)*:
- ❒ Medication trials
- ❒ Management decision
- ❒ Stroke prevention and/or anticoagulation
- ❒ Decision/access to ablation
- ❒ Decision/access to cardioversion
- ❒ Patient education and self-care management

Consultant request *(Check one)*:
- ❒ Next available consultant *(Rapid referral)*
- ❒ Preferred consultant: _____

Interpreter needed ❒ No ❒ Yes: Language

Comments

Please complete the following checklist and attach reports for all items checked "done"

	Done (include report)	Not done	Comments
Exercise stress test			
Holter monitor			
Coronary angiogram			
Echocardiogram			
Other cardiac tests			
Relevant consultant notes			

****Please include a list of current medications****

Physician/NP signature: _____ **Fax #:** _____

Please include fax number if you wish confirmation of receipt of referral. We will contact the patient directly to make an appointment.

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