Peter Munk Cardiac Centre

UHN

Complex Ablation Referral Form

Date of Referral: (M/D/Y)________________________	**Patient Demographics**
Urgency Rating: ☐Urgent (while still in hospital) ☐Elective	**Patient's Present Location:** ☐Home ☐Hospital ☐Ward Name and no. **Translator Needed**: ☐No ☐Yes Language:
Brief History:	**Referring MD:** **Family MD:**
Heart Failure Class: ☐ I ☐ II ☐ III ☐ IV **LV Function:** RNA ☐ Yes, when (m/d/y) No LVEF: % **ECHO**: required to be within the last 14 days **MI** ☐ yes, when (m/d/y)_________ ☐ No **CABG**: ☐ yes, when (m/d/y) ______ ☐ No **PCI:** ☐ yes, when (m/d/y) _______ ☐ No **New heart failure diagnosis within last 6 months**: ☐ Yes, when (m/d/y) _____________ ☐No **Cath:** ☐Yes, when (m/d/y) _______☐ No	**Arrhythmia: AF ☐ AFL ☐ AT ☐ SVT ☐ VT ☐** **Co-Morbid conditions** ☐ Presence of co-morbid illness • ☐ Chronic renal failure requiring dialysis • ☐ Irreversible brain damage from pre-existing cerebral disease (i.e. debilitating CVA/Dementia) • ☐ Major psychiatric disease or active drug abuse ☐ Chronic pulmonary disease requiring home oxygen **Please list other conditions and significant past history:**
Creatinine:_______ **TSH:** ______ **Lytes**: ________ **INR**: ______ **CBC:** __________________ **Medication History:** **Anticoagulation History**: Coumadin ☐Yes☐ NoAnticoagulation Indication: ☐A fib ☐ Valve ☐Previous Stroke ☐Other LV thrombus: ☐ Yes ☐ No **when** (m/d/y)___ ACE: Inhibitor ☐ Yes ☐ No ☐ Not tolerated ARB ☐ Yes ☐ No ☐Not tolerated Beta blockers ☐ Yes ☐ No ☐ Not tolerated Anti-arrhythmic medication ☐ Yes ☐ No	**QRS width:** ______ **Atrial Fib:** ☐ Yes ☐ No **persistent** ☐ **paroxysmal** ☐ **Pacemaker:** ☐ Yes ☐ No **AICD:** ☐ Yes ☐ No **List of all medications and current doses:**

*****In addition to this form please fax the following: Documentation of VT (12 lead ECG if possible), Echo, Muga, Labs, history and physical as well as progress notes.**

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