London Health Sciences Centre

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ICD & CRT REFERRAL FORM

REFERRING PHYSICIAN INFORMATION

Name		Referral Date		Referral Type	☐ Primary ☐ Secondary ☐ Re-referral
Name of Institution		Contact Information (phone, email, fax)			

PATIENT INFORMATION

Name		Address			
Contact Information (phone, email, fax)		DOB	/ /	Gender	☐ Male ☐ Female
Current Patient Status	☐ Inpatient ☐ Outpatient	OHIP No. & Version Code			

PLEASE SELECT THE APPROPRIATE BOXES

		COMMENTS
☐ ☐	Non-ischemic cardiomyopathy for a minimum of 9 months and Optimal Rx Ischemic cardiomyopathy and a minimum of 3 months post coronary revascularization, CABG, etc… DATE of Most Recent Myocardial Infarction: ________________	
☐ ☐	LVEF ≤ 30% - determined while patient was stable and after 3 months on Optimal Rx MUGA – DATE: ________________ EF Result: ____________ Echo – DATE: ________________ EF Result: ____________	
☐	NYHA Class Determined: ☐ NYHA Class I ☐ NYHA II ☐ NYHA III ☐ NYHA IV	
☐	Documented Congestive Heart Failure for a period ≥ 6 months	
☐	Documented sustained VT or cardiac arrest due to VF	
☐	Adequate doses of medications for a period ≥ 3 months: ☐ Carvedilol ☐ Bisoprolol ☐ Metoprolol ☐ ACE-I ☐ ARB ☐ Other:__________ ☐ Lasix ☐ Spironolactone	
☐	QRS Duration: ______________ ms	
☐	Discussion held with patient about ICD and patient is now aware of this referral	

PLEASE SELECT YES OR NO

Yes	No		COMMENTS
☐	☐	Atrial Fibrillation? If yes, ☐ Permanent or Persistent (≥ 6 months) ☐ Paroxysmal Oral anticoagulants: ☐ Warfarin (Coumadin) ☐ Clopidogrel (Plavix) ☐ ASA	
☐	☐	Prosthetic Heart Valve or Structural Valvular Disease	
☐	☐	Diabetes Mellitus? If yes, Diabetes Control: ☐ None ☐ Diet ☐ Oral Agent ☐ Insulin ☐ Unknown	
☐ ☐ ☐	☐ ☐ ☐	Symptomatic Bradycardia Hypertension Cognitive Impairment	
☐	☐	HX of CVA/TIA? If yes, disability level: ☐ Recovered ☐ Minor Persisting Disability ☐ Major Persisting Disability	
☐	☐	Chronic obstructive lung disease?	
☐	☐	History of Drug/ETOH, major psych illness? If yes, current Drug/ETOH, major psych illness: ___________________	
☐	☐	History of Cancer? If yes, ☐ Inactive cancer (cured in remission) ☐ Active cancer	
☐	☐	Patient on dialysis or chronic renal failure? If applicable, most recent serum creatinine: ___________________	

IMPORTANT! PLEASE ATTACH:

☐ Recent Consult ☐ MUGA/ECHO Results ☐ ECG Results ☐ Cardiac Catheterization Results
☐ Other: ___________________________________

PLEASE FAX COMPLETED FORM TO: ARRHYTHMIA SERVICE 519.663.3782

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Referral Guidelines for ICD & CRT Therapy Consideration

Based on CCS/CHRS Recommendations

Secondary Prevention
Previous Cardiac Arrest,
VF or Sustained VT
(induced or spontaneous)

If admitted, do NOT discharge patient

→ Refer for ICD consideration, unless contraindicated

Primary Prevention (Ischemic & Non-Ischemic)
& CRT Patients

Assess or Re-Assess and Document
Patient History, LVEF*& NYHA Functional Class

Optimal Medical Therapy
Patient is receiving OMT for a minimum of 3 months
(Medications may include: Beta Blockers, ACE Inhibitors, Spironolactone, Statins)

Yes

- LVEF ≤ 30%**
  - Non-Ischemic Cardiomyopathy for minimum of 9 months → NYHA Class II or III → **Refer for ICD consideration, unless contraindicated**
  - Prior MI → **Refer for ICD consideration, unless contraindicated**
- LVEF ≤ 35%
  - Cardiomyopathy with QRS ≥120ms NSR → NYHA Class III or IV → **Refer for CRT† consideration, unless**

CCN Ontario | Arrhythmia Coordinator LHSC
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*LVEF measured 30 days post MI or 90 days post revascularization procedure
**For appropriate non-ischemic patients, EF of 31% to 35% will also be considered
† Inclusion of defibrillator based on physician discretion