

ICD & C	RT REF	ERRAL	FORM
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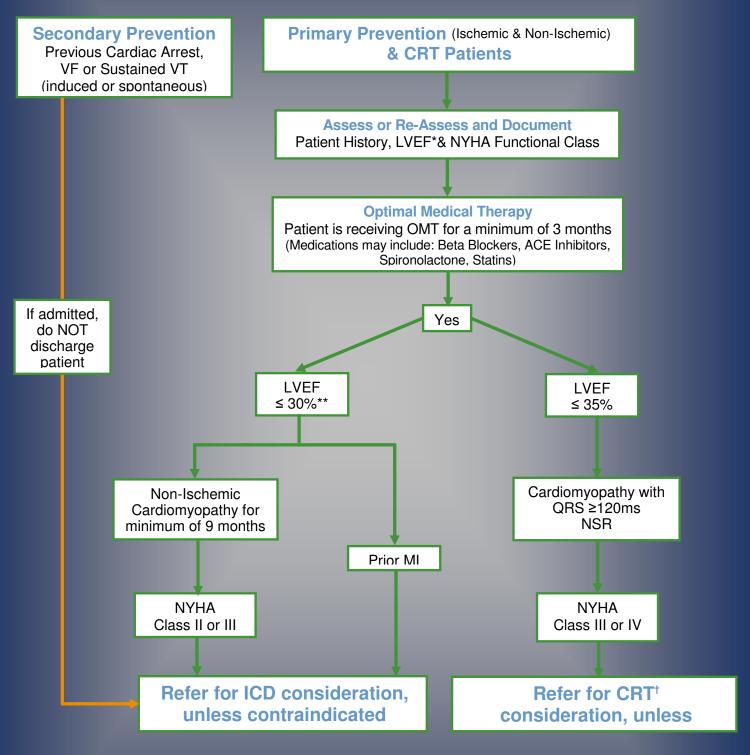
REFERRING PHYSICIAN INFORMATION													
Name			Referral Date			Referral Type	🗌 Prir	mary 🗌	Secondary	Re-referral			
Name o Institut			on K)										
PATIENT INFORMATION													
Name		Addre	ss										
Contact Information (phone, email, fax)					DOB /			/	Gender	Male Female			
Current Patient Status Dutpatient 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 \leq 30% - determined while patient was stable and after 3 months on Optimal Rx MUGA - DATE:												
	NYHA Class Determined: NYHA Class I NYHA II NYHA III NYHA IV												
	Doc	umented Congestive Heart Failure for a pe	riod ≥ 6 mc	onths									
	Doc	umented sustained VT or cardiac arrest du	e to VF										
	□ Lasix □ Spironolactone												
	QRS	S Duration: ms											
	Disc	ussion held with patient about ICD and pa	tient is now	aware of this refe	ral								
PLEA	SE SE	LECT YES OR NO						COMMENTS					
Yes	No												
		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 creatinin											
IMPC	ORTAI	NT! PLEASE ATTACH:											
Recent Consult MUGA/ECHO Results ECG Results Cardiac Catheterization Results Other:													

PLEASE FAX COMPLETED FORM TO: ARRHYTHMIA SERVICE 519.663.3782

London Health Sciences Centre

DR. RAYMOND YEE | DR. ANDREW KRAHN | DR. GEORGE KLEIN | DR. LORNE GULA | DR. ALLAN SKANES Referral Guidelines for ICD & CRT Therapy Consideration

Based on CCS/CHRS Recommendations



CCN Ontario | Arrhythmia Coordinator LHSC Deb Murphy | Tel: 519.685.8500 ext. 35303 | Fax: 519.663.3782

*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