MOUNT SINAI HOSPITAL

Joseph and Wolf Lebovic Health Complex
600 University Avenue
Toronto, Ontario, Canada M5G 1X5
D 808 Front TRIAL (Rev. 06.2014) Page 1 of 2

Pacemaker Referral Form

Clearly imprint patient identification card

Patient Name: ☐ Male ☐ Female	DOB ________ (YYYY MM DD)
Address:	
Phone:	
HCN and Version Code	
Patient Current Location:	

Please complete form and include test results, ECG and Rhythm Strips
FAX to: 416-586-4599 Or EMAIL to pacemakerreferral@mtsinai.on.ca

REFERRING PHYSICIAN INFORMATION

Name		Referral date: (YYYY MM DD)		Institution	
Phone		Fax		Email	

PROCEDURE REQUESTED

☐ Consultation
☐ New Pacemaker Implantation
☐ Implantable Loop Recorder
☐ Pacemaker Generator Replacement
☐ Lead Replacement/Reposition
☐ Pacemaker System Revision (eg CRT upgrade)

Current device manufacturer and pacemaker clinic ________

Device location ☐ Left ☐ Right

REASON FOR REQUEST (IMPORTANT! PLEASE PROVIDE ECG'S, RHYTHM STRIPS ☐)

☐ Pacing for Symptomatic Bradycardia: ☐ AV Block ☐ Sinus node dysfunction ☐ Syncope NYD
☐ Device Malfunction (eg lead fracture)________
☐ CRT (Provide ECG and documentation of LVEF) ☐ for HF treatment ☐ LV dysfunction and anticipated RV pacing

Provide brief history/reason for referral or attach clinical notes ________

URGENCY?

Patient aware of referral ☐ Yes ☐ No

☐ Urgent (1-2 days) Temporary lead in situ? ☐ Yes ☐ No If Yes, inserted ________ (YYYY MM DD)
☐ While in hospital ☐ Elective

CURRENT MEDICATIONS

☐ ASA ☐ Yes ☐ No
Clopidogrel/Prasugrel/Ticagrelor: ☐ Yes ☐ No
Insulin ☐ Yes ☐ No
Anticoagulation: ☐ Yes ☐ No
If yes, which agent: ________
Last dose? ________ (YYYY MM DD)

INVESTIGATIONS

INR:
Most recent value ________
Test date ________ (YYYY MM DD)

LVEF (%): ☐ greater than or equal to 50
☐ 31-50
☐ less than or equal to 30

(☐ Is ICD a consideration?)

MEDICAL CONDITIONS – CHECK ALL THAT APPLY AND PROVIDE DETAILS BELOW

Condition	Yes	No
Mechanical valve	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No
Chronic Renal Failure	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
MRSA/VRE positive	☐ Yes	☐ No
Fever in previous 48 hrs	☐ Yes	☐ No
Drug Allergies	☐ Yes	☐ No

(specify) ________
☐ Other ________

Date	Time	Print Name	Signatures
(YYYY MM DD)	(HH : MM)		________, M.D. Reviewed by

Copy Distribution: White Original → Patient Chart Yellow Copy → Consulting Physician

Pacemaker Referral Form

FOR CARDIAC CATHETERIZATION LABORATORY USE ONLY

For reviewing physician to complete ☐ RW ☐ SB ☐ MM ☐ OTHER

PPM recommendation:

☐ Require more information from referring MD ______________________

☐ PPM not indicated

☐ Book PPM Type: ☐ DDD ☐ VVI ☐ CRT-PPM Urgency: ☐ 24-48 hours ☐ within 7 days ☐ next available

Preferred vendor ______________________

☐ Pacemaker clinic to arrange admission Additional pre-op orders: ______________________

☐ Cath lab to arrange admission

☐ MD to arrange transfer

☐ MSH inpatient pre-op orders completed

Procedure scheduled: ____________ (YYYY MM DD) Time: ________ (HH : MM) Implanter: ______________

Vendor: ______________________

Date	Time	Print Name	Signatures
________ (YYYY MM DD)	________ (HH : MM)	______________________	______________________, M.D. Reviewed by