HRM HEART RHYTHM MANAGEMENT

Patient Name:

Date of Birth (yyy/mm/dd):

Health Card #:

CR #:

Address:

Phone # Home:
Work:

Email:

ELECTROPHYSIOLOGY/CARDIOLOGY REQUISITION & REFERRAL

Referring Practitioner: _____

Referring Practitioner Signature: _____

Referring Practitioner Fax #: _____ **Email:** _____

Height: _____ **cm** **Weight:** _____ **kg**

Test required:

- ☐ Ambulatory BP
- ☐ Bicycle stress test
- ☐ CRT optimization
- ☐ Dobutamine stress echo
- ☐ Echocardiogram
- ☐ Electrocardiogram
- ☐ EP study
- ☐ Exercise stress echo
- ☐ Holter Monitor ☐ 48-hour ☐ 24-hour
- ☐ ICD implantation
- ☐ Inherited heart disease clinic and genetic testing
- ☐ Pacemaker implantation
- ☐ Pacemaker/ICD/ILR interrogation
- ☐ Provocative drug challenge (Long QT, CPVT, Brugada Syndrome)
- ☐ Signal average ECG
- ☐ Tilt table testing
- ☐ Transesophageal echocardiogram
- ☐ Treadmill Exercise Test (Bruce/Modified protocol)
- ☐ Other: _____

Clinical History (check appropriate box)

- ☐ Unknown
- ☐ Diagnosed Myocardial Infarction
- ☐ Possible Ischemia Infarction
- ☐ Pulmonary Disease
- ☐ Hypertension
- ☐ Palpitations or Syncope
- ☐ Predominant Mitral Stenosis
- ☐ Aortic Stenosis/Aortic or Mitral Regurgitation
- ☐ Congenital Heart Disease
- ☐ Pericarditis

Medications (check all appropriate boxes)

- ☐ Unknown
- ☐ None of the following
- ☐ Digitalis
- ☐ Quinidine or Procainamide or Amiodarone
- ☐ Antihypertensives
- ☐ Diuretics
- ☐ Beta Blockers
- ☐ Calcium Channel Blockers
- ☐ Other: _____

Clinical Information/reason(s) for test:

EP consultation required ☐ Yes ☐ No

Copy to Family Physician: Dr. _____

SUBMIT

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