UNIVERSITY OF OTTAWA HEART INSTITUTE
INSTITUT DE CARDIOLOGIE DE L'UNIVERSITÉ D'OTTAWA

ARRHYTHMIA REGISTRY

Referrals for Pacemaker/ICD must be requested using the Pacemaker/ICD referral form HEA 110.

Outpatient Referral to be faxed to 613-696-7123

Inpatient Referral to be faxed to 613-696-7144

Unique number _____

Name _____
SURNAME *FIRST NAME* *INITIAL*

❑ Male ❑ Female DOB _____/____/____ Age _____

Ontario Health # _____

OR ❑ Other Province ❑ Other Country ❑ Not Available

Address _____

Postal Code Phone

PLEASE ATTACH ALL ARRHYTHMIA DOCUMENTATION.
All documentation must be received prior to entering into the triage process.

REFERRING PHYSICIAN TO COMPLETE

REASON FOR REFERRAL

❑ EPS ❑ EPS/Ablation ❑ Arrhythmia Clinic
❑ Biopsy ❑ Other:

METHOD OF DOCUMENTATION
(check all that apply and send documentation)

❑ ECG ❑ Loop ❑ Holter
❑ Other:

CLINICAL HISTORY/PHYSICAL EXAM

Is the patient competent to consent? ❑ No ❑ Yes
Is patient on coumadin? ❑ No ❑ Yes
Does patient suffer from Dementia? ❑ No ❑ Yes
Does the patient have a physical or mental condition making it difficult to lie flat for more than 3 hours with minimal sedation? ❑ No ❑ Yes

COMORBIDITY ASSESSMENT

NYHA ❑ 1 ❑ 2 ❑ 3 ❑ 4 Height cm Weight: kg

	No	Yes	
Creatinine _____			Date _____ yy ____ mm
Dye Allergy	❑	❑	
Latex Allergy	❑	❑	
Dialysis	❑	❑	
Diabetes	❑	❑	Insulin Oral Meds
Previous CABG	❑	❑	Date _____ yy ____ mm
Previous PCI	❑	❑	Date _____ yy ____ mm
Hypertension	❑	❑	
COPD	❑	❑	
Congestive Heart Failure	❑	❑	
Vascular Disease	❑	❑	
Vascular Disease History	❑	❑	CAD, PVD or other atherosclerosis
Prior stroke/TIA/Thromboembolism	❑	❑	
Recent MI	❑	❑	Date _____ yy ____ mm

History of MI in months ❑ Unknown
❑ 1-3 ❑ more than 3-6 ❑ more than 6-12 ❑ more than 12

Referral Physician signature: **Date (yyyy/mm/dd):**

EP PHYSICIAN TO COMPLETE

PRIMARY DIAGNOSIS

❑ SVT ❑ Paroxysmal AF ❑ Atrial Tachycardia (probable)
❑ AVRT - WPW ❑ Persistent AF ❑ VT ❑ Probable RVOT VT or PVCS ❑ Probable LVOT VT or PVCS
❑ AVNRT ❑ Atypical Atrial Flutter ❑ VT secondary to CAD ❑ VT secondary to non-ischemic CM
❑ Other: _____ ❑ Typical Atrial Flutter ❑ Epicardial VT ❑ Other VT: _____

❑ Urgent inpatient: 24-48 hours ❑ Semi-Urgent (_____ weeks) ❑ Priority (15-60 days) ❑ Elective / Routine

EP Physician signature: **Date (yyyy/mm/dd):**

AVNRT	Atroventricular nodal re-entry tachycardia	AV	Atrial ventricular	CAD	Coronary artery disease
CM	Cardiomyopathy	COPD	Chronic obstructive pulmonary disease	ICD	Internal cardiac defibrillator
EF	Ejection fraction	CABG	Coronary artery bypass graft	CRT	Cardiac resynchronization therapy
EPS	Electrophysiology study	MI	Myocardial infarction	PVD	Peripheral vascular
NYHA	New york heart association classification	PCI	Percutaneous coronary intervention	TIA	Transient ischemic attack
PVCS	Premature ventricular complex syndrome	SVT	Supraventricular tachycardia	VT	Ventricular tachycardia disease
RVOT	Right ventricular outflow tract	LVOT	Left ventricular outflow tract	WPW	Wollf Parkinsons White

Patient name: Chart no.:

EP PHYSICIAN TO COMPLETE

ELECTROPHYSIOLOGY BOOKING SHEET

Section A- Procedure

❑ EPS ❑ EPS / Ablation

Section B - F Pre-Procedure Testing

❑ CT scan required Booked Date: _____ (booked by EP Admin Staff)
❑ Other DI Testing _____ Booked Date: _____ (booked by EP Admin Staff)
❑ TEE required Booked Date: _____ (booked by Waitlist Mgmt office)

Section C - Anesthesiology Requirements

Anesthesia care required ❑ Yes ❑ No

Section D - Mapping Requirements ❑ NAVX ❑ CARTO ❑ ICE ❑ Cryo ❑ Other :

Section E	Medications	Discontinuation Instructions
1		
2		
3		
4		

Anticoagulants: ❑ No ❑ Yes Type: _____ Reason: _____

Coumadin Instructions:
❑ Stop 4 days before -no substitution required
❑ Stop 4 days before- admit 2 days prior for conversion to IV heparin
❑ Stop 4 days before - low molecular weight heparin ❑ Bridge in ❑ Bridge out
❑ Continue Coumadin and do procedure with therapeutic INR
❑ Check INR pre-procedure: ❑ 4 days ❑ 1 day
❑ Patient needs weekly INR monitoring pre-ablation for _____ weeks

Other Anti-coagulant instructions:

Physician Signature for medication orders: **Date** (yyyy/mm/dd):

Section F- EP Physician to do Procedure: Supported with: _____

❑ Birnie ❑ Davis ❑ Sadek ❑ Green ❑ Lemery ❑ Nair ❑ Nery ❑ Redpath ❑ Any

EP Physician Signature: **Date** (yyyy/mm/dd):

WAIT LIST TO COMPLETE

Date Booked: _____ yy____ /mm ____ /dd Procedure MD: _____
Patient Letter / Brochure Sent: _____ yy____ /mm ____ /dd
Admit Date: _____ yy____ /mm ____ /dd ❑ Admit ❑ DU ❑ PAU ❑ PAU w/ GA ❑ PAU w/ BHcg
Procedure Date: _____ yy____ /mm ____ /dd
Translator Required: ❑ N ❑ Y Specify: _____
Comments: