Reset Form Print Form

BRITISH COLUMBIA INHERITED ARRHYTHMIA PROGRAM (Vancouver Site)

REFERRAL

DATE OF REFERRAL:

Suite # 211-1033 Davie Street Vancouver BC V6E 1M7
Phone: 604-682-2344 ext. 66766 **Fax:** 604-806-9474

NAME: (last, first)		TELEPHONE Home: Work: Cell:
ADDRESS:		
CITY:	POSTAL CODE:	
DOB: (yy/mmm/dd)	HEALTH CARD #:	☐ INTERPRETER NEEDED Language:
ALTERNATE CONTACT NAME:		RELATIONSHIP:

REFERRING CLINICIAN:

NAME:	Specialty:	Billing number:
ADDRESS:		
TELEPHONE:		FAX:

URGENCY:

☐ Routine
☐ Semi-Urgent
☐ Urgent -reason:

Patient pregnant?
☐ Yes ☐ No

POINT OF REFERRAL:

☐ Emergency
☐ Physician's Office
☐ Unknown
☐ Outpatient Clinic
☐ Inpatient (location):
☐ Other (specify):

REASON FOR REFERRAL:

☐ Long QT Syndrome
☐ Brugada Syndrome
☐ Arrhythmogenic Right Ventricular Cardiomyopathy
☐ Catecholaminergic Polymorphic Ventricular Tachycardia
☐ Positive Genetic Test Result:
(condition tested for) _____

☐ Unexplained sudden cardiac arrest
☐ Familial Sudden Death (relationship): _____
☐ SIDS (relationship to the deceased): _____
☐ Other (details): _____

DIAGNOSIS:
☐ Confirmed
☐ Suspected
☐ Family History

SYMPTOMATIC
☐ YES (details):
_____

FAMILY MEMBER(S) REFERRED:
☐ Yes Relationship: _____
☐ No
☐ Unknown

TESTS COMPLETED (please attach copies)**:**

☐ ECG ☐ Holter Monitor ☐ Stress Test
☐ Echocardiogram ☐ Cardiac MRI ☐ Signal Averaged ECG
☐ Genetic Testing ☐ Biopsy ☐ Other: _____

DRUG CHALLENGE:
☐ epinephrine ☐ procainamide

GENETICS:

Family known to Genetics? ☐ Yes ☐ No ☐ Unknown Location seen (province, country):

OTHER PERTINENT INFORMATION:

Referring Physician Signature: _____

Family Physician: (please print) _____

FAX completed referral AND all pertinent discharge summaries, blood work, cardiac investigations (ECG, stress test, echo, etc.) to 604-806-9474