



# BRITISH COLUMBIA INHERITED ARRHYTHMIA PROGRAM (Victoria site)

## REFERRAL

DATE OF REFERRAL:		1 Hospital Way, Victoria BC, V8Z 6R Phone: 250-727-4461 Fax: 250-727-4295	
NAME: (last, first)		TELEPHONE	
ADDRESS:		Home:	
CITY:		Work:	
POSTAL CODE:		Cell:	
DOB: (yy/mm/dd)	HEALTH CARD #:	<input type="checkbox"/> INTERPRETER NEEDED Language: _____	
ALTERNATE CONTACT NAME:		RELATIONSHIP:	
<b>REFERRING CLINICIAN:</b>			
NAME:		Specialty:	Billing number:
ADDRESS:			
TELEPHONE:		FAX:	
<b>URGENCY:</b>		<b>POINT OF REFERRAL:</b>	
<input type="checkbox"/> Routine	<b>Patient pregnant?</b>	<input type="checkbox"/> Emergency	<input type="checkbox"/> Outpatient Clinic
<input type="checkbox"/> Semi-Urgent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Inpatient (location): _____
<input type="checkbox"/> Urgent -reason: _____		<input type="checkbox"/> Unknown	<input type="checkbox"/> Other (specify): _____
<b>REASON FOR REFERRAL:</b>			
<input type="checkbox"/> Long QT Syndrome	<input type="checkbox"/> Unexplained sudden cardiac arrest		
<input type="checkbox"/> Brugada Syndrome	<input type="checkbox"/> Familial Sudden Death (relationship): _____		
<input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy	<input type="checkbox"/> SIDS (relationship to the deceased): _____		
<input type="checkbox"/> Catecholaminergic Polymorphic Ventricular Tachycardia	<input type="checkbox"/> Other (details): _____		
<input type="checkbox"/> Positive Genetic Test Result: (condition tested for) _____			
<b>DIAGNOSIS:</b>	<b>SYMPTOMATIC</b>	<b>FAMILY MEMBER(S) REFERRED:</b>	
<input type="checkbox"/> Confirmed	<input type="checkbox"/> YES (details): _____	<input type="checkbox"/> Yes Relationship: _____	
<input type="checkbox"/> Suspected	_____	<input type="checkbox"/> No	
<input type="checkbox"/> Family History	_____	<input type="checkbox"/> Unknown	
<b>TESTS COMPLETED (please attach copies):</b>			
<input type="checkbox"/> ECG	<input type="checkbox"/> Holter Monitor	<input type="checkbox"/> Stress Test	<b>DRUG CHALLENGE:</b>
<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Cardiac MRI	<input type="checkbox"/> Signal Averaged ECG	<input type="checkbox"/> epinephrine <input type="checkbox"/> procainamide
<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> Biopsy	<input type="checkbox"/> Other: _____	
<b>GENETICS:</b>			
Family known to Genetics? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Location seen (province, country): _____	
<b>OTHER PERTINENT INFORMATION:</b>			

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 250-727-4295**