Reset Form Print Form

BRITISH CLOUMBIA INHERITED ARRYTHMIA 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 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
☐ Echocardiogram
☐ Genetic Testing
☐ Holter Monitor
☐ Cardiac MRI
☐ Biopsy
☐ Stress Test
☐ Signal Averaged ECG
☐ 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 250-727-4295