SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Heart Rhythm Triage Office
Tel: (905) 895-4521 x 2572, Fax: (905) 830-5806

Health Record #: ______________ Complete or place barcoded patient label here
Patient Name: (Print first, last) ______________
DOB: dd / mm / yy Age: ______ ❑ Female ❑ Male
OHIP #: ______________ Version Code: ______________
Account #: ______________ Date of Admission: dd / mm / yy

Heart Rhythm Program Procedure Referral ❑ Inpatient ❑ Outpatient

Patient Name: (print first, last)	Date of Birth: dd / mm / yy
Address: Street Number and Name Apartment City Province Postal Code	
Contact Number:	**Alternate Number:**
Health Card Number:	**Copies to:** ❑ Family Physician ❑ Other Doctor:
Referring Physician: (print first, last)	**Family Physician:** (print first, last)
Phone:	**Phone:**
Fax:	**Fax:**

Referral For: ❑ Office/Clinical Consultation ❑ Permanent Pacemaker ❑ Implant Cardioverter-defibrillator
❑ Cardioversion ❑ Biventricular/Cardiac Resynchronization Therapy ❑ Implantable loop recorder
❑ Electrophysiology Study/Ablation

Reason for Referral: ____

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THE FOLLOWING DOCUMENTATION MUST ACCOMPANY THE REFERRAL BEFORE A PLAN OF CARE CAN BE DETERMINED.

- 12 Lead ECG (need actual tracing not report)
- Echo report (full quantitative study)
- Full Holter/Loop/Telemetry reports and rhythm strips
- Consultation note including symptoms and medication list

Additional information: (if available)

❑ Recent labs ❑ Chest x-ray ❑ Cardiac MRI ❑ MUGA/MIBI ❑ Stress test ❑ Cardiac Catheterization/PCI notes

Comments:

Referring Physician Signature: **Date:** dd / mm / yy

S-HEARPPR