Hôpital général St-Boniface General Hospital

PRE-OP PERMANENT PACEMAKER OR DEFIBRILLATOR IMPLANT PROTOCOL

For referrals from other WRHA / RHA facilities to St. Boniface General Hospital
Tel: (204) 237-2431 **Fax: (204) 231-2541**

DATE OF CONSULT: _____ **Date of Birth:** _____

PATIENT NAME: _____

CENTRE: _____ **FAX:** _____

- **SUBMIT THE REFERRAL FORM (ADRF) WITH ALL REQUIRED INFORMATION BY FAX** as soon as possible after the patient has been referred for device implant.

REFERRAL WILL NOT BE REVIEWED UNTIL ALL THE INFORMATION HAS BEEN RECEIVED

- The Pacemaker Nurse, in consultation with the implanting Physician, will review the data and may phone to clarify instructions.
- If the patients' status changes after arrangements have been made, please call the Pacemaker Clinic @ (204) 237-2431, Monday – Friday from 08:00 – 16:00. At other times (after hours) page the on-call Implant Cardiologist (Hospital Paging # (204) 233-8563)
- IS YOUR PATIENT ON ANY ISOLATION? PLEASE INFORM THE CLINIC ASAP.

REQUIRED INFORMATION:

Referral Form (ADRF) ***or*** **medical history / physical**

A complete medication list (MAR), including OTC and non-traditional therapies

Accurate height and weight

12-lead EKG with rhythm strip during current hospitalization

Documentation / strips of relevant arrhythmias

Recent chest x-ray report. (*if available*).

Blood gas results (*if available*) on patients with respiratory compromise

Interpreter requirements, if required

Discharge requirements, if applicable

Demographics, including complete and accurate address, phone number and birthdate.

Blood work – CBC, Electrolytes, BUN, creatinine, INR

Hôpital St-Boniface Hospital

Cardiac Sciences Program / Programme des sciences cardiaques

ARRHYTHMIA DEVICE REFERRAL FORM

PLEASE FAX COMPLETED FORM TO
ARRHYTHMIA SERVICE @ 204-231-2541

PATIENT INFORMATION

Name: _____ Date of birth: D D M M M Y Y Y Y ❑ Male ❑ Female

Address: _____ Contact information: _____ (phone or fax) Allergies: _____

Current patient location: ❑ inpatient name of institution: _____ ❑ outpatient MSHC# _____ PHIN # _____

REFERRING PHYSICIAN INFORMATION

Name: _____ Referral date: D D M M M Y Y Y Y Referral type: ❑ ICD ❑ CRT ❑ Pacemaker ❑ ICM / Loop

Contact information: _____ (phone or fax) Family MD: _____

PLEASE SELECT THE APPROPRIATE BOXES

❑ Bradycardia ❑ 3rd degree AV block ❑ Trifascicular block ❑ 2nd degree type I AV block ❑ 2nd degree type II AV block
❑ Sinus node dysfunction ❑ RBBB ❑ LBBB ❑ Atrial fibrillation / flutter with slow ventricular response
❑ Temporary wire: Vascular access site: _____ Insertion date: D D M M M Y Y Y Y

❑ Non-ischemic cardiomyopathy for a minimum of 9 months and on optimal medical therapy.

❑ Ischemic cardiomypathy and minimum of 3 months post coronary revascularization or 1 month post myocardial infarction
(date of most recent myocardial infarction: D D M M M Y Y Y Y) Angiogram/Stents Date: D D M M M Y Y Y Y
CABG Date: D D M M M Y Y Y Y

LVEF < 30% (or < 35% for CRT) following appropriate time period as above (Preferred Method - MUGA)

❑ MUGA - Date: D D M M M Y Y Y Y ❑ Echo - Date: D D M M M Y Y Y Y

❑ MIBI - Date: D D M M M Y Y Y Y ❑ Cardiac MRI - Date: D D M M M Y Y Y Y

Please attach test report(s)

❑ Is an MRI conditional device required ❑ No ❑ Yes (explain) _____

❑ NYHA Class: ❑ I ❑ II ❑ III ❑ IV

■ **Must include 12 Lead ECG and arrhythmia strips**
■ Attach medication list
■ Discussion held with patient about device referral and patient now aware of this referral. *(must be done prior to referral)*
■ CBC ■ INR ■ Electrolytes ■ Creatinine
■ Recent history and physical including history of ASD or VSD, CABG, prosthetic valve, other cardiac history

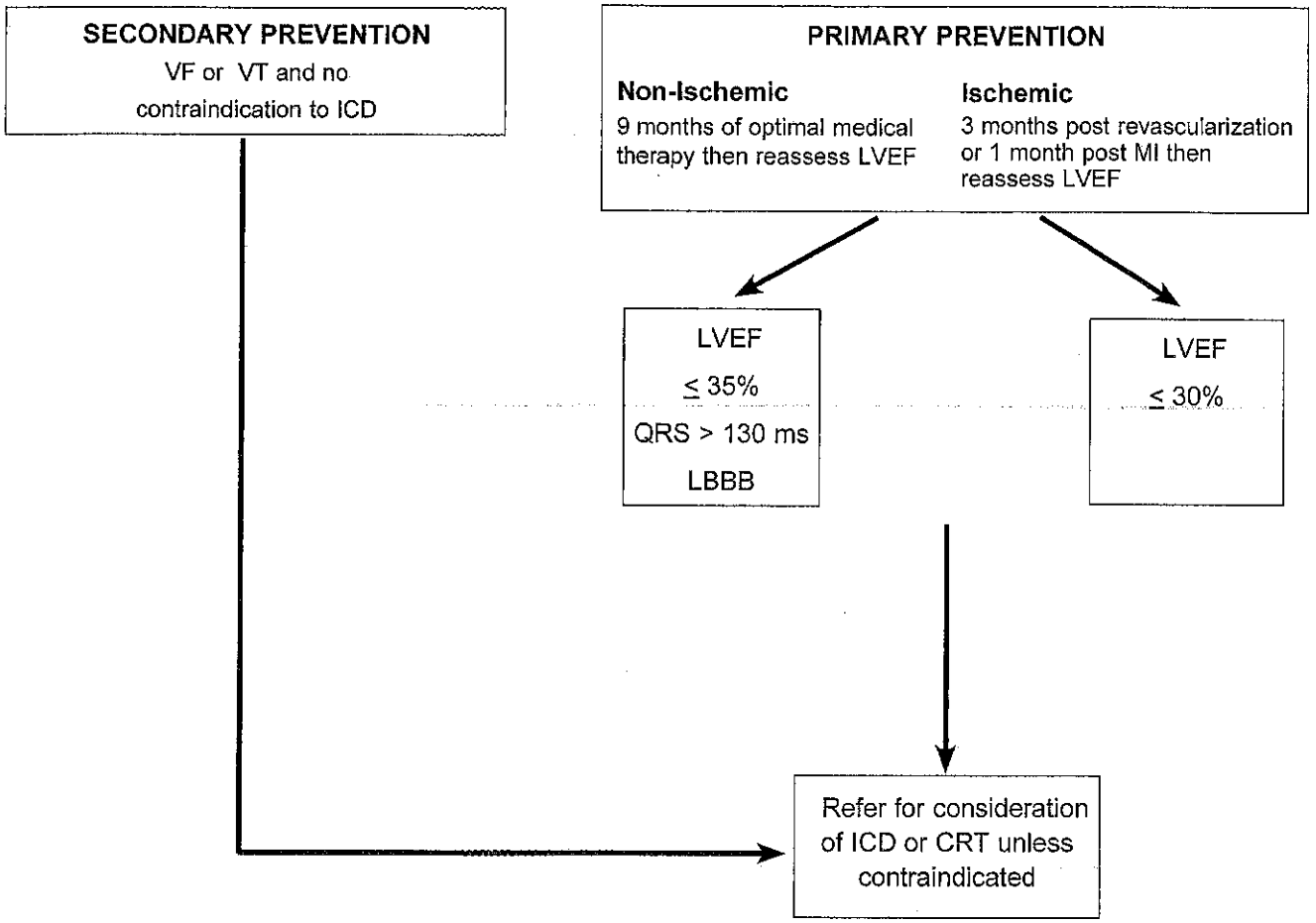
PLEASE SELECT YES or NO

Yes	No	
❑	❑	Atrial fibrillation - If yes, ❑ Permanent (> 6 months) ❑ Persistent ❑ Paroxysmal
❑	❑	Oral anticoagulants:
		❑ Warfarin (Coumadin) ❑ ASA
		❑ Dabigatran / Apixiban / Rivaroxaban ❑ Clopidogrel / Ticagrelor
		❑ Other _____
❑	❑	Diabetes mellitus ❑ Diet ❑ Oral hypoglycemic ❑ Insulin ❑ Unknown
❑	❑	**Symptomatic bradycardia ❑ Syncope ❑ Presyncope ❑ Dyspnea ❑ Fatigue ❑ Hypotension**
❑	❑	Hypertension
❑	❑	Cognitive impairment - If yes, provide details: _____
❑	❑	History of CVA / TIA - If yes, disability level: ❑ Recovered ❑ Minor persisting disability ❑ Major persisting disability
❑	❑	Chronic obstructive lung disease ❑ Obstructive sleep apnea ❑ CPAP
❑	❑	History of drug / ETOH abuse
❑	❑	Major psychiatric illness - If yes, provide details: _____
❑	❑	History of cancer If yes: Inactive cancer (cured / remission) Active cancer (details): _____
❑	❑	Does patient use walking aid or wheelchair _____
❑	❑	Current or prior central line. If yes, vascular access site: _____
❑	❑	Dialysis - If yes, vascular access site: _____
❑	❑	Able to lie flat (minimum of 3 hours)
❑	❑	**Able to sign consent**

Other relevant information: _____

GENERAL REFERRAL GUIDELINES FOR ICD & CRT DEVICE CONSIDERATION

Based on CCS / CHRS Recommendations



Arrhythmia Service

Tel: 204-237-2431 Fax: 204-231-2541

SBH Paging: 204-237-2053

Legend:

ASA - Acetyl-salicylic acid (Aspirin)	CVA - Cerebrovascular Accident	MIBI - Myocardial Perfusion Scan
ASD - Atrial Septal Defect	Echo - Echocardiogram	MRI - Magnetic Resonance Imaging
AV - Atrioventricular	ETOH - Alcohol	MUGA - Multigated Acquisition Scan
CABG - Coronary Artery Bypass Graft	ICD - Implantable Cardioverter Defibrillator	NYHA - New York Heart Association
CBC - Complete Blood Count	ICM - Implantable Cardiac Monitor	RBBB - Right Bundle Branch Block
CCS - Canadian Cardiovascular Society	INR - International Normalized Ratio	TIA - Transient Ischemic Attack
CHRS - Canadian Heart Rhythm Society	LBBB - Left Bundle Branch Block	VF - Ventricular Fibrillation
CPAP - Continuous Positive Airway Pressure	LVEF - Left Ventricular Ejection Fraction	VSD - Ventricular Septal Defect
CRT - Cardiac Resynchronization Therapy	MI - Myocardial Infarction	VT - Ventricular Tachycardia