



# London Health Sciences Centre

Referral to:  
**LHSC ARRHYTHMIA SERVICE**  
**LEAD EXTRACTION REFERRAL FORM**  
 339 Windermere Road, London ON N6A 5A5  
 Telephone: 519-663-3746 / Fax: 519-663-3782

DATE OF REFERRAL: (YYYY/MM/DD)					
PATIENT NAME:				<input type="checkbox"/> IN PATIENT <input type="checkbox"/> OUT PATIENT	
ADDRESS:			TELEPHONE: Home:		
CITY:		POSTAL CODE:		Work:	
D.O.B.: (YYYY/MM/DD)		HEALTH CARD NUMBER:			Version Code:
<b>REFERRING PHYSICIAN:</b>					
NAME:			BILLING NUMBER:		
ADDRESS:					
TELEPHONE:			FAX:		
<b>DIAGNOSIS / REASON FOR REFERRAL:</b>					
<b>INDICATION FOR EXTRACTION:</b>					
<input type="checkbox"/> Infection: <input type="checkbox"/> Pocket <input type="checkbox"/> Systemic <input type="checkbox"/> Organism: _____			Urgency: <input type="checkbox"/> Emergent (<48 hrs) <input type="checkbox"/> Urgency (<7 days) <input type="checkbox"/> Elective		
<input type="checkbox"/> Obstruction/Access <input type="checkbox"/> Debulking					
<b>DEVICE DETAILS:</b>					
Original Implant Date: (YYYY/MM/DD) _____					
Most Recent Implant Date (if different): (YYYY/MM/DD) _____					
Device Type:		<input type="checkbox"/> Dual Chamber PPM		<input type="checkbox"/> Single Chamber PPM	
		<input type="checkbox"/> Dual Chamber ICD		<input type="checkbox"/> Single Chamber ICD	
				<input type="checkbox"/> BIV PPM	
				<input type="checkbox"/> BIV ICD	
Pacing Mode: _____					
Dependent:		<input type="checkbox"/> Yes <input type="checkbox"/> No		Intrinsic Rate and Rhythm: _____	
Will the patient need a new device? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>DEVICE INFORMATION:</b>					
LEAD	CHAMBER	MODEL	MANUFACTURER	AGE	COMMENT
1					
2					
3					
4					