



### ICD & CRT REFERRAL FORM

#### REFERRING PHYSICIAN INFORMATION

Name	Referral Date	Referral Type	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Re-referral
Name of Institution	Contact Information (phone, email, fax)		

#### PATIENT INFORMATION

Name	Address	DOB	/ /	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Contact Information (phone, email, fax)	Current Patient Status		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	OHIP No. & Version Code	

#### PLEASE SELECT THE APPROPRIATE BOXES

#### COMMENTS

<input type="checkbox"/>	Non-ischemic cardiomyopathy for a minimum of 9 months and Optimal Rx	
<input type="checkbox"/>	Ischemic cardiomyopathy and a minimum of 3 months post coronary revascularization, CABG, etc... DATE of Most Recent Myocardial Infarction: _____	
<input type="checkbox"/>	LVEF ≤ 30% - determined while patient was stable and after 3 months on Optimal Rx	
<input type="checkbox"/>	MUGA - DATE: _____ EF Result: _____	
<input type="checkbox"/>	Echo - DATE: _____ EF Result: _____	
<input type="checkbox"/>	NYHA Class Determined: <input type="checkbox"/> NYHA Class I <input type="checkbox"/> NYHA II <input type="checkbox"/> NYHA III <input type="checkbox"/> NYHA IV	
<input type="checkbox"/>	Documented Congestive Heart Failure for a period ≥ 6 months	
<input type="checkbox"/>	Documented sustained VT or cardiac arrest due to VF	
<input type="checkbox"/>	Adequate doses of medications for a period ≥ 3 months: <input type="checkbox"/> Carvedilol <input type="checkbox"/> Bisoprolol <input type="checkbox"/> Metoprolol <input type="checkbox"/> ACE-I <input type="checkbox"/> ARB <input type="checkbox"/> Other: _____ <input type="checkbox"/> Lasix <input type="checkbox"/> Spironolactone	
<input type="checkbox"/>	QRS Duration: _____ ms	
<input type="checkbox"/>	Discussion held with patient about ICD and patient is now aware of this referral	

#### PLEASE SELECT YES OR NO

#### COMMENTS

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Atrial Fibrillation?	
<input type="checkbox"/>	<input type="checkbox"/>	If yes, <input type="checkbox"/> Permanent or Persistent (≥ 6 months) <input type="checkbox"/> Paroxysmal	
<input type="checkbox"/>	<input type="checkbox"/>	Oral anticoagulants: <input type="checkbox"/> Warfarin (Coumadin) <input type="checkbox"/> Clopidogrel (Plavix) <input type="checkbox"/> ASA	
<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Heart Valve or Structural Valvular Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus?	
<input type="checkbox"/>	<input type="checkbox"/>	If yes, Diabetes Control: <input type="checkbox"/> None <input type="checkbox"/> Diet <input type="checkbox"/> Oral Agent <input type="checkbox"/> Insulin <input type="checkbox"/> Unknown	
<input type="checkbox"/>	<input type="checkbox"/>	Symptomatic Bradycardia	
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	
<input type="checkbox"/>	<input type="checkbox"/>	Cognitive Impairment	
<input type="checkbox"/>	<input type="checkbox"/>	HX of CVA/TIA?	
<input type="checkbox"/>	<input type="checkbox"/>	If yes, disability level: <input type="checkbox"/> Recovered <input type="checkbox"/> Minor Persisting Disability <input type="checkbox"/> Major Persisting Disability	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive lung disease?	
<input type="checkbox"/>	<input type="checkbox"/>	History of Drug/ETOH, major psych illness?	
<input type="checkbox"/>	<input type="checkbox"/>	If yes, current Drug/ETOH, major psych illness: _____	
<input type="checkbox"/>	<input type="checkbox"/>	History of Cancer? If yes, <input type="checkbox"/> Inactive cancer (cured in remission) <input type="checkbox"/> Active cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Patient on dialysis or chronic renal failure?	
<input type="checkbox"/>	<input type="checkbox"/>	If applicable, most recent serum creatinine: _____	

#### IMPORTANT! PLEASE ATTACH:

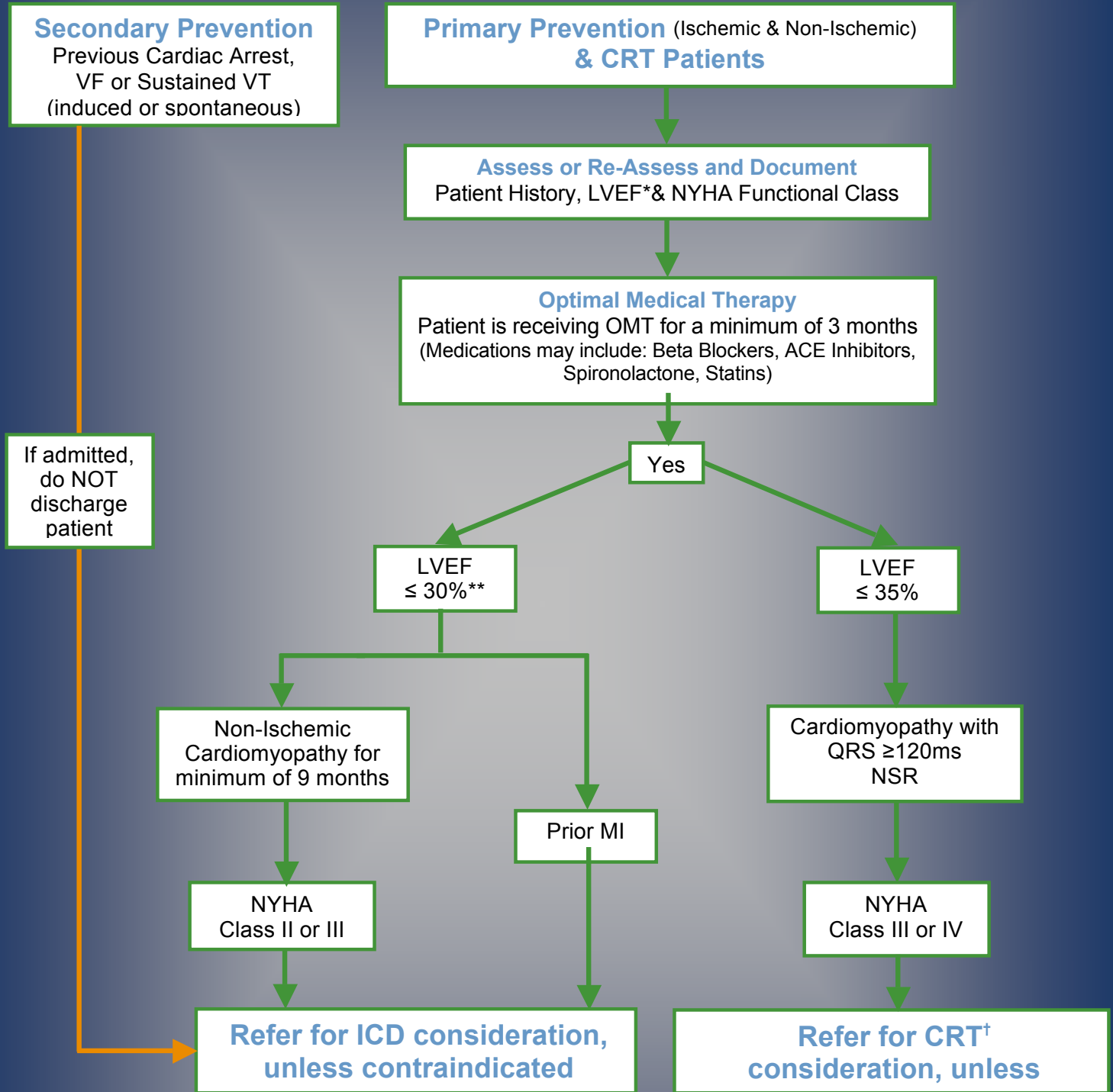
<input type="checkbox"/> Recent Consult	<input type="checkbox"/> MUGA/ECHO Results	<input type="checkbox"/> ECG Results	<input type="checkbox"/> Cardiac Catheterization Results
<input type="checkbox"/> Other: _____			

**PLEASE FAX COMPLETED FORM TO: ARRHYTHMIA SERVICE 519.663.3782**



# Referral Guidelines for ICD & CRT Therapy Consideration

Based on CCS/CHRS Recommendations



CCN Ontario | Arrhythmia Coordinator LHSC

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\*LVEF measured 30 days post MI or 90 days post revascularization procedure  
\*\*For appropriate non-ischemic patients, EF of 31% to 35% will also be considered

† Inclusion of defibrillator based on physician discretion