

Atrial Fibrillation Clinic
 #211 – 1033 Davie Street
 Vancouver, BC V6E 1M7
 Phone: 604-806-9475
 Fax: 604-806-9476

Name:	
DOB:	M/F
PHN:	MRN:
Address:	
Telephone number:	

REFERRAL TO AF CLINIC

Number of pages (including this one) _____

PLEASE NOTE: Incomplete referrals will be returned

Date: _____ Referring physician/NP _____

Referred from: Primary care ED Internist Cardiologist
 (Check all) EP Waitlist EP Other: _____

Purpose of referral (Check one): Opinion Case review and letter
 Consultation Patient assessed in clinic
 Consultation and management Patient assessed in clinic with on-going management until objectives met
 Post-ablation follow-up

AF diagnosis (Check one): Newly diagnosed
 Previously diagnosed
 Other: _____

Comments

Indications for referral (Check all that apply):
 Assistance with medication trials
 Assistance with management decision (Rate control; Rate vs. rhythm)
 Assistance with stroke prevention and/or anticoagulation
 Assistance with decision/access to ablation
 Assistance with decision/access to cardioversion
 Assistance with patient education and self-care management

Previously managed by (Check all that apply)
 Primary care
 Cardiologist
 Electrophysiologist
 AFib Clinic
 Other: _____

Previous ablation: No Yes – Date: _____
 Unknown

Consultant request (Check one):
 Next available consultant (Rapid referral)
 Preferred consultant: Dr. Chakrabarti Dr. C. Kerr
 Dr. S. Tung Dr. J Yeung

Interpreter needed: No Yes

Please complete the following checklist and attach reports for all items checked “done”

	Done (include report)	Not done	Unknown	Comments
12 Lead ECG REQUIRED				
Exercise stress test				
Holter monitor				
Cardiac echo				
Coronary angiogram				
Cardiac CT/MRI				
Other cardiac tests				
Relevant consultant notes				

Please include a list of current medications

Physician/NP signature: _____ Fax # _____

Please include fax number if you wish confirmation of receipt of referral

We will contact the patient directly to make an appointment