

**Pacemaker Interrogation Referral Form**

Pacemaker clinic EXT 2126 FAX (416) 469 6538

**mhuyn**

 Outpatient In-patient Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **REASON FOR REFERRAL** |
|  **Pre op assessment** Type of surgery:   Date: |  **Pacemaker interrogation** *Interrogation at MGH* ***DOES NOT******replace*** *routine follow up at patient’s home clinic* |  **ICD/CRT-D interrogation***The only available service is a device interrogation for* ***report/data printing*** |
| **Arrhythmia/Syndromes** (if applicable) |
|  Syncope/presyncope |  Pacemaker malfunction |  Ventricular arrhythmias |
|  Other (specify):  |
| **REQUIRED INFORMATION** |
| Please indicate where patient attends their **follow up appointments**: |
| **Device brand** |
|  Biotronik |  Boston |  Medtronic |  Sorin |  St. Jude/Abbott |
| **PLEASE COMPLETE REFERRAL AND FAX TO (416) 469 6538** |

Referring physician (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_