MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Pacemaker Insertion Referral Form

Fax: 416-469-6538

Date: _____ **Attending Cardiologist:** _____
Referring Physician: _____

Estimate of Urgency:

- ☐ Urgent (In hospital)
- ☐ Urgent (within 2 weeks)
- ☐ Elective

Requested Procedure:

- ☐ Single Chamber
- ☐ Dual Chamber

Specify Indications: _____

Pre-op orders:

- ☑ Referral to Pacemaker Clinic for Implanting Physician Assessment
- ☐ Medical Consult Required – ***Insulin dependent Diabetic***
- ☐ Anesthesia Consult Required
  - ☐ ***Unable to lie flat***
  - ☐ ***Anticipated need for general anesthesia or deep sedation secondary to lack of patient cooperation (cognitive impairment or severe claustrophobia)***

Patient Specifics:

Y / N: Coumadin
Y / N: Cognitive Impairment
Y / N: Urgent: (Admitted: Y / N)
Y / N: Diabetic: (Insulin: Y / N)
Y / N: Allergies: _____

- ☐ Holter Report Available
- ☐ Previous Heart/ Thoracic surgery
- ☐ LV function _____
- ☐ Previous MI

Brief History: _____

_____

_____

Current Medications: _____

_____

Patient Location:

☐ Home ☐ Nursing Home _____ ☐ Hospital _____
☐ Translator Required - Language: _____

Signature of referring physician: _____