

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_