MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

## Pacemaker Interrogation Referral Form

Pacemaker clinic EXT 2126 FAX (416) 469 6538

☐ Outpatient ☐ In-patient Unit: _____ Ext: _____

| **REASON FOR REFERRAL** | | |
|---|---|---|
| ☐ **Pre op assessment**<br>Type of surgery:<br><br>Surgical Date: | ☐ **Pacemaker interrogation**<br><br>*Interrogation at MGH **DOES NOT replace** routine follow up at patient's home clinic* | ☐ **ICD/CRT-D interrogation**<br><br>*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 provide AT MINIMUM ONE of the following)** | | |
| Please indicate which hospital patient attends their **DEVICE 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: _____