MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Cardiac Implantable Electronic Device (CIED) Referral Form

Instructions: Fax 416-469-6538 or email referral to

MGHHeartFunctionClinic@tehn.ca

PATIENT IDENTIFICATION

Priority: ☐ Emergency (in-patient) ☐ Urgent (within 2 weeks) ☐ Elective

Referral Information:

Referring Physician: Name: _____ CPSO Number: _____

Requested Procedural Physician: _____

Wait Location: Indicate hospital name and ward: _____

OR select another location below:

☐ Home ☐ Rehabilitation Facility ☐ Medical Facility Outside of Province ☐ Medical Facility Outside of Country

Patient contact number: _____ Facility contact number: _____

Pre-Procedure:

Anticoagulant: _____

Last dose date (YYYY/MM/DD) and time (hhmm):

_____

Target INR: _____ if on VKA

Select requested interventions/tests:	Yes	No	Pending	Date completed (YYYY/MM/DD)
Echo				
Transesophogeal echo				
CT				
MRI				
Anesthesia consult				
Overnight stay				

Procedure Required:

Implantable Cardioverter Defibrillator (ICD)

☐ ICD-VVI

☐ ICD-DDD ☐ ICD-VDD

Cardiac Resynchronization Therapy (CRT)

☐ CRT-D ☐ CRT-P

Permanent Pacemaker (PPM)

☐ PPM VVI ☐ PPM DDD ☐ PPM VDD

Reason:

☐ New device ☐ Upgrade

☐ Replacement ☐ Advisory ☐ ERI or EOL

Other: _____

Current device type: _____

Current lead type: _____

Requested device manufacturer: _____

Device Indication:

☐ Primary Prevention

☐ Secondary Prevention

Dependency:

☐ Dependent

☐ Not Dependent

Additional Notes:

☐ Medical consult required – Insulin Dependent Diabetic

☐ Anticipated need for general anesthesia or deep sedation secondary to lack of patient cooperation (e.g. cognitive impairment)

☐ Other:

Legend:

VVI - ventricle, ventricle, inhibition
DDD - dual sensing, dual firing, dual pacing
VDD - ventricle, dual, dual
CRT-D - cardiac resynchronization therapy - defibrillator
CRT-P - cardiac resynchronization therapy - pacemaker
CPSO - College of Physicians and Surgeons of Ontario
VKA - Vitamin K Antagonist
ERI - Elective replacement indicator
EOL - End of life
TYRX - TYRX is absorbable antibacterial envelope

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PATIENT IDENTIFICATION

Reasons for Referral: Primary reason for the patient's referral is required. Select the appropriate reason by circling P to indicate one Primary Reason for Referral, and S, if applicable, to indicate one Secondary Reason for Referral.

Arrhythmia:

P	S	Atrial Flutter
P	S	Atypical Atrial Flutter
P	S	Atrioventricular Nodal Re-entrant Tachycardia (AVNRT)
P	S	Atrial Tachycardia
P	S	Paroxysmal Atrial Fibrillation
P	S	Persistent Atrial Fibrillation
P	S	Ventricular Fibrillation
P	S	Ventricular Tachycardia
P	S	Wolff-Parkinson-White Syndrome
P	S	AV Block first degree
P	S	AV Block second degree type 1
P	S	AV Block second degree type 2
P	S	AV Block third degree
P	S	Bifascicular Block
P	S	Trifascicular Block
P	S	Tachy-Brady Syndrome

Other:

P	S	Heart Disease of Other Etiology
P	S	Protocol (Research/Employment)
P	S	Syncope
P	S	Sinus Node disease
P	S	Hypersensitive Carotid Sinus Syndrome
P	S	Hypertrophic Cardiomyopathy (HCM)
P	S	Left ventricular ejection fraction ≤ 35%

Coronary Disease:

S	Stable Angina (or Equivalent)
S	Unstable Angina (or Equivalent)
S	Non-ST-Segment Elevation Myocardial Infarction (NSTEMI)
S	ST-Segment Elevation Myocardial Infarction (STEMI)

Valve Disease:

S	Aortic Stenosis
S	Aortic Regurgitation
S	Other Valvular
S	**Congenital/Structural**

Heart Transplant:

S	Recipient

Diagnostic Information:

Height: _____ cm Weight: _____ kg

Left Ventricular Ejection Fraction: _____ % ☐ Grade 1 ☐ Grade 2 ☐ Grade 3 ☐ Grade 4 ☐ Not Done

History of Congestive Heart Failure: ☐ Yes ☐ No

COORDINATOR (RN) USE ONLY

Inpatient admit date: (YYYY/MM/DD):_____ Accepted (YYYY/MM/DD): _____

Received (YYYY/MM/DD): _____ Scheduled (YYYY/MM/DD): _____

Signature:_____ Print Name: _____ Credentials:_____

Physician signature: _____ Print name: _____ Date (YYYY/MM/DD): _____

Legend: AVNRT - Atrioventricular nodal reentry tachycardia
AV - Atrioventricular