



London Heart Rhythm Program
 339 Windermere Road, London ON N6A 5A5
 Telephone: 519-914-4606 | Fax: 226-636-6006

<input type="checkbox"/> INPATIENT (ADMITTED) <input type="checkbox"/> OUTPATIENT		Referral Date: (yyyy/mm/dd)
PATIENT NAME:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other:
ADDRESS:		TEL: Home: Work: Cell:
CITY:	POSTAL CODE:	
D.O.B.: (yyyy/mm/dd)	HEALTH CARD #:	Version Code:
REFERRING PHYSICIAN		
NAME:		BILLING NUMBER:
ADDRESS or CPSO #:		
TELEPHONE:		FAX:
REASON FOR REFERRAL		
<input type="checkbox"/> Syncope <input type="checkbox"/> Palpitations/Suspected Arrhythmia <input type="checkbox"/> Bradycardia/AV Block <input type="checkbox"/> Atrial Fibrillation/Flutter <input type="checkbox"/> SVT/WPW <input type="checkbox"/> VT <input type="checkbox"/> PVCs/NSVT <input type="checkbox"/> Inherited Arrhythmia REQUEST TYPE: <input type="checkbox"/> EP Consultation <input type="checkbox"/> Device Follow-up <input type="checkbox"/> Cardioversion <input type="checkbox"/> Pacemaker <input type="checkbox"/> ICD/CRT <input type="checkbox"/> Ablation <input type="checkbox"/> Lead Extraction		
Provide additional details:		
MEDICATIONS		
ANTICOAGULATION: <input type="checkbox"/> No <input type="checkbox"/> Yes → _____ (drug/dose)		
REFERRAL DOCUMENTS (please fax if available)		
<input type="checkbox"/> Most recent clinical note (diagnoses + medications) <input type="checkbox"/> ECG or rhythm strip demonstrating the arrhythmia (PLEASE INCLUDE TRACINGS) <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Other Investigations: (Angiogram, MRI, CT etc..)		
<p>All referrals are physician-triaged, potentially life-threatening arrhythmias are prioritized</p> <p>Missing clinical notes or rhythm documentation may delay triage</p> <p>FAX TO: 226-636-6006</p>		
E-mail: office@lhrp.ca Website/Patient Resources: LHRP.ca		