Electrophysiology Study and Ablation Referral Form

CorHealth Ontario

SHN Scarborough Health Network
Centenary Hospital: 2867 Ellesmere Rd., Scarborough, ON M1E 4B9 – 416-284-8131

Instructions: Send to Regional Cardiac Centre directly. Do NOT send to CorHealth Ontario. Select only one option, unless noted otherwise.

Patient Information

First Name:	Middle Name:	Last Name:

Health Card Number: Auth. Issuing:	DOB: YYYY-MM-DD	MRN:

Street Address:	Suite:	City:	Prov./State:

Postal/Zip Code:	Country: If outside Canada	Primary Phone:	Alternate Phone:

Race: Race is self-identified by the patient. Patient may identify as one or more option.

☐ Black ☐ East/Southeast Asian ☐ Indigenous (First Nations, Métis, Inuk/Inuit) ☐ Latino

☐ Middle Eastern ☐ South Asian ☐ White ☐ Other

The following options cannot be indicated with any other option: ☐ Unknown ☐ Prefer Not to Answer ☐ Not Collected

Referral Information

Referring Physician: Name and/or CPSO Number

Wait Location: Indicate Hospital name OR select a location

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

Procedure Required

Diagnostic Study: ☐Electrophysiology Study

Ablation: ☐ Standard ☐ Complex

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

Other:

P S Heart Disease of Other Etiology
P S Protocol (Research/Employment)
P S Syncope

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 **Cardiomyopathy**

S **Congenital/Structural**

S **Heart Failure**

Heart Transplant:

S Donor
S Recipient

Additional Notes:

Diagnostic Information

Height:	Weight:	Left Ventricular Ejection Fraction: Only required for ablation referrals, indicate either a percentage or a grade				
_____ cm	_____ kg	_____ %	☐ Grade 1	☐ Grade 2	☐ Grade 3	☐ Grade 4	☐ Not Done

Referring Physician Signature:	Date: YYYY-MM-DD