BRITISH COLUMBIA INHERITED ARRHYTHMIA PROGRAM (Vancouver Site)

REFERRAL

Suite # 211-1033 Davie Street, Vancouver BC V6E 1M7
Phone: 604-682-2344 ext. 66766 **Fax:** 604-806-9474

DATE OF REFERRAL:		
NAME: (last, first)		TELEPHONE Home: Work: Cell:
ADDRESS:		
CITY:	POSTAL CODE:	
DOB: (yy/mmm/dd)	HEALTH CARD #:	☐ INTERPRETER NEEDED Language:
ALTERNATE CONTACT NAME:		RELATIONSHIP:

REFERRING CLINICIAN:

NAME:	Specialty:	Billing number:
ADDRESS:		
TELEPHONE:		FAX:

URGENCY:

☐ Routine
☐ Semi-Urgent
☐ Urgent -reason:

Patient pregnant? ☐ Yes ☐ No

POINT OF REFERRAL:

☐ Emergency ☐ Outpatient Clinic
☐ Physician's Office ☐ Inpatient (location):
☐ Unknown ☐ Other (specify):

REASON FOR REFERRAL:

☐ Long QT Syndrome
☐ Brugada Syndrome
☐ Arrhythmogenic Right Ventricular Cardiomyopathy
☐ Catecholaminergic Polymorphic Ventricular Tachycardia
☐ Positive Genetic Test Result:
(condition tested for) _____

☐ Unexplained sudden cardiac arrest
☐ Familial Sudden Death (relationship): _____
☐ SIDS (relationship to the deceased): _____
☐ Other (details): _____

DIAGNOSIS:

☐ Confirmed
☐ Suspected
☐ Family History

SYMPTOMATIC

☐ YES (details):

FAMILY MEMBER(S) REFERRED:

☐ Yes Relationship: _____
☐ No
☐ Unknown

TESTS COMPLETED (please attach copies)**:**

☐ ECG ☐ Holter Monitor ☐ Stress Test
☐ Echocardiogram ☐ Cardiac MRI ☐ Signal Averaged ECG
☐ Genetic Testing ☐ Biopsy ☐ Other: _____

DRUG CHALLENGE:
☐ epinephrine ☐ procainamide

GENETICS:

Family known to Genetics? ☐ Yes ☐ No ☐ Unknown Location seen (province, country):

OTHER PERTINENT INFORMATION:

Referring Physician Signature: _____

Family Physician: (please print) _____

FAX completed referral AND all pertinent discharge summaries, blood work, cardiac investigations (ECG, stress test, echo, etc.) to 604-806-8723