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Providence HEALTH CARE

PHC LASER LEAD EXTRACTION PROGRAM REFERRAL

* 1 0 8 9 5 *

Cardiology Referral

Date of Referral: _____

PATIENT INFORMATION

Patient's name: (last, first) _____ Gender: ☐ Male ☐ Female

PHN: _____ DOB: (dd/mmm/yyyy) _____ ☐ Other: _____

Allergies: _____ Height: _____cm Weight: _____kg

Phone: (home) _____ (cell) _____ (work) _____

Preferred phone: ☐ Home ☐ Cell ☐ Work Email: _____

Primary Care Provider: _____ Cardiologist: _____

Referring MD: _____ Phone: _____

URGENCY

☐ Urgent inpatient (within 72 hours) ☐ Elective outpatient

☐ Urgent outpatient (within 2 weeks)

INDICATIONS FOR REFERRAL

☐ Infection
- ☐ Blood culture results: _____
- ☐ Pocket culture results: _____

☐ Debulking

☐ Access needed in occluded/stenotic vein

☐ Life threatening arrhythmia secondary to retained lead

☐ Lead failure

☐ Recall/Advisory

☐ Requires MRI

☐ Other: _____

DEVICE TYPE AND LEAD HISTORY

☐ Single Chamber PM ☐ Dual Chamber PM

☐ Leadless PM

☐ Single Chamber ICD ☐ Dual Chamber ICD

☐ Subcutaneous ICD ☐ Extravascular ICD

☐ CRT PM ☐ CRT ICD

Type of lead: ☐ Atrial ☐ Ventricular

Date lead inserted: _____

PPM dependent: ☐ Yes ☐ No

Battery life remaining: _____

Previous surgeries: _____

ADDITIONAL CLINICAL INFORMATION ATTACHED

☐ Consult letter ☐ Device Interrogation Reports

☐ ECHO (TTE and/or TEE) ☐ ECG ☐ Chest x-ray

NOTES:

SEND COMPLETED REQUEST AND RELEVANT CLINICAL INFORMATION TO:
Cardiac Surgery Triage Coordinator FAX: 604-675-2644