Providence HEALTH CARE

ATRIAL FIBRILLATION (AF) CLINIC
#211 - 1033 Davie Street
Vancouver, B.C. V6E 1M7
Ph: 604-806-9475 Fax: 604-806-9476

Name: _____

DOB: (m/d/y) _____

PHN: _____ **Age:** _____ **Sex**: Male / Female

Address: _____

_____

Telephone: _____

REFERRAL

Date of referral: _____

☐ **Next available consultant** ∗OR∗ **Preferred consultant:** (wait times may vary depending on consultant)
☐ Dr. Chakrabarti ☐ Dr. Deyell ☐ Dr. Kerr ☐ Dr. Tung ☐ Dr. Yeung

☐ **Interpreter required -** Language: _____

CLINICAL INFORMATION

New onset of Atrial Fibrillation (AF): ☐ Yes ☐ No

Type: ☐ Paroxysmal ☐ Persistent ☐ Permanent

ER visit within last month: ☐ Yes ☐ No

Anticoagulation: ☐ Yes ☐ No

Type of anticoagulation: _____

$CHADS_2$ Score:

History of CHF	☐ Yes = 1 pt	☐ No
History of hypertension	☐ Yes = 1 pt	☐ No
Age over 75 years	☐ Yes = 1 pt	☐ No
History of diabetes	☐ Yes = 1 pt	☐ No
Stroke or TIA	☐ Yes = 2 pts	☐ No

Total score: _____ **/ 6**

SEVERITY OF AF SYMPTOMS:

☐ **SAF Class 0:** Asymptomatic with respect to AF

☐ **SAF Class 1:** Minimal and/or infrequent symptoms **or** single episode of AF without syncope or heart failure

☐ **SAF Class 2:** Mild symptoms with persistent/permanent AF **or** rare episodes of paroxysmal AF (fewer than 1/yr)

☐ **SAF Class 3:** Moderate symptoms on most days with persistent/permanent AF **or** more frequent episodes or more severe symptoms with paroxysmal AF

☐ **SAF Class 4:** Severe symptoms with persistent/paroxysmal AF, **and/or** frequent or highly symptomatic episodes of paroxysmal AF, **and/or** syncope thought to be due to AF **and/or** congestive heart failure due to AF

PROVIDE THE FOLLOWING INFORMATION WITH THIS REFERRAL:

(Referrals will not be accepted without this information)

☐ Consult notes & list of current medications
☐ **12 lead ECG or rhythm strips documenting AF**

Results of previous tests:

☐ Holter monitor **with rhythm strips**
☐ Echocardiogram
☐ Stress Test
☐ Cardiac CT / MRI / Angiogram

REFERRING PHYSICIAN/NP

_____ _____
Signature Printed name

_____ _____
Billing # Fax #

Fax completed referral and additional information to the AF Clinic 604-806-9476

Acknowledgement of referral within 48 hours (to be completed by the AF Clinic)

☐ The AF Clinic will contact the patient within the next _____ day(s)

☐ We require the following additional information before we can book the patient: