

PHC LASER LEAD EXTRACTION PROGRAM REFERRAL



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:	☐ Cell ☐ Work	Email:		
Primary Care Provider:		Cardiologist:		
Referring MD:		Phone:		
URGENCY				
☐ Urgent inpatient (within 7	2 hours)	☐ Elective outpatient		
☐ Urgent outpatient (within	2 weeks)			
INDICATIONS FOR REFERRAL				
☐ Infection		☐ Life threatening arr	rhythmia secondary to retained lead	
☐ Blood culture results:		☐ Lead failure		
☐ Pocket culture results:		☐ Recall/Advisory		
☐ Debulking		☐ Requires MRI		
Access needed in occluded/stenotic vein		☐ Other:		
DEVICE TYPE AND LEAD HISTORY				
☐ Single Chamber PM	☐ Dual Chamber PM	Type of lead:	al 🗌 Ventricular	
☐ Leadless PM		Date lead inserted:		_
☐ Single Chamber ICD	☐ Dual Chamber ICD	PPM dependent:	Yes No	
☐ Subcutaneous ICD	☐ Extravascular ICD	Battery life remaining:		_
☐ CRT PM	☐ CRT ICD	Previous surgeries:		_
ADDITIONAL CLINICAL INFORMATION ATTACHED				
☐ Consult letter	☐ Device In	terrogation 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