



**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	
ADDRESS:		Home:	
CITY:		Work:	
POSTAL CODE:		Cell:	
DOB: (yy/mm/dd)		HEALTH CARD #:	
ALTERNATE CONTACT NAME:		<input type="checkbox"/> INTERPRETER NEEDED Language: _____	
		RELATIONSHIP:	
REFERRING CLINICIAN:			
NAME:		Specialty:	Billing number:
ADDRESS:			
TELEPHONE:		FAX:	
URGENCY:		POINT OF REFERRAL:	
<input type="checkbox"/> Routine <input type="checkbox"/> Semi-Urgent <input type="checkbox"/> Urgent -reason: _____		<input type="checkbox"/> Emergency <input type="checkbox"/> Physician's Office <input type="checkbox"/> Unknown	
Patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Inpatient (location): _____ <input type="checkbox"/> Other (specify): _____	
REASON FOR REFERRAL:			
<input type="checkbox"/> Long QT Syndrome <input type="checkbox"/> Brugada Syndrome <input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy <input type="checkbox"/> Catecholaminergic Polymorphic Ventricular Tachycardia <input type="checkbox"/> Positive Genetic Test Result: (condition tested for) _____		<input type="checkbox"/> Unexplained sudden cardiac arrest <input type="checkbox"/> Familial Sudden Death (relationship): _____ <input type="checkbox"/> SIDS (relationship to the deceased): _____ <input type="checkbox"/> Other (details): _____	
DIAGNOSIS:		SYMPTOMATIC	
<input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Family History		<input type="checkbox"/> YES (details): _____ _____	
		FAMILY MEMBER(S) REFERRED:	
		<input type="checkbox"/> Yes Relationship: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	
TESTS COMPLETED (please attach copies):			
<input type="checkbox"/> ECG <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Genetic Testing		<input type="checkbox"/> Holter Monitor <input type="checkbox"/> Cardiac MRI <input type="checkbox"/> Biopsy	
<input type="checkbox"/> Stress Test <input type="checkbox"/> Signal Averaged ECG <input type="checkbox"/> Other: _____		DRUG CHALLENGE: <input type="checkbox"/> epinephrine <input type="checkbox"/> procainamide	
GENETICS:			
Family known to Genetics? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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