Oakville Trafalgar Memorial Hospital

CARDIAC DEVICE AND ARRHYTHMIA SERVICES REFERRAL

Phone: 905-338-4363
Fax: 905-815-5126
Dr. Kostas Ioannou, MD, FRCPC

Patient Name: ______________________________

Health Card #: ______________________________

❐ Male ❐ Female DOB: ______________

Address: ______________________________

____

Phone #: ______________________________

Please Fax form and supporting documents to: 905-815-5126

Date of Referral	Referring Physician	Phone # Billing #	Family Physician
Is Patient Competent to Consent? ❐ Yes ❐ No	Has a Substitute Decision Maker been informed of consult request? ❐ Yes ❐ No	Substitute Decision Maker Name	Contact #

Reason for Referral (if urgent please specify):

❐ Elective ______________________________

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❐ Urgent ______________________________

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*** Emergent / Inpatients – Please contact on-call Cardiologist and fax referral**

Attach copies of:

☒ Recent clinic/consult notes
☒ ECG
☒ Echo
☒ Medications and Allergies
☒ Anticoagulants or antiplatelet (list):__________________

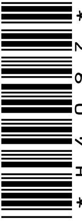
❐ Relevant Holter/Rhythm strip

❐ Device/pacemaker clinic note (if non Oakville site)

❐ Ejection Fraction (EF%) if known:___________

❐ Other:__________

Incomplete referrals will be returned



Relevant Medical History (attach relevant documentation):

❐ History of CHF
❐ Ischemic heart disease or history of MI
❐ Implanted cardiac device (list type if known):
❐ Prosthetic heart valve (mechanical or bioprosthetic):
❐ AFIB (paroxysmal/persistent or chronic):
❐ DVT/PE
❐ Renal Failure (List Cr:)__________________________
❐ Diabetes
❐ Other:____

		Referring Physician Signature
CLINIC USE ONLY	Date Referral Received	Date of Surgery