London Health Sciences Centre

Referral to:
LHSC ARRHYTHMIA SERVICE
LEAD EXTRACTION REFERRAL FORM

339 Windermere Road, London ON N6A 5A5
Telephone: 519-663-3746 / **Fax:** 519-663-3782

DATE OF REFERRAL: (YYYY/MM/DD)			
PATIENT NAME:			☐ IN PATIENT ☐ OUT PATIENT
ADDRESS:		TELEPHONE:	Home:
CITY:	POSTAL CODE:		Work: Cell:
D.O.B.: (YYYY/MM/DD)	HEALTH CARD NUMBER:		Version Code:
FOR INPATIENT REFERRALS - Facility Name, Dept. and Contact:			

REFERRING PHYSICIAN:

NAME:	BILLING NUMBER:
ADDRESS:	
TELEPHONE:	FAX:

DIAGNOSIS / REASON FOR REFERRAL:

INDICATION FOR EXTRACTION:

☐ Infection: ☐ Pocket ☐ Systemic ☐ Organism: _____
☐ Obstruction/Access
☐ Debulking
☐ Erosion
☐ Lead Abandonment

Urgency: ☐ Emergent (<48 hrs) ☐ Urgent (<7 days) ☐ Elective

DEVICE DETAILS:

Original Implant Date: (YYYY/MM/DD) _____

Most Recent Implant Date (if different): (YYYY/MM/DD) _____

Device Type: ☐ Dual Chamber PPM ☐ Single Chamber PPM ☐ BiV PPM
☐ Dual Chamber ICD ☐ Single Chamber ICD ☐ BiV ICD

Pacing Mode: _____ Date of Implant: (YYYY/MM/DD)

Manufacturer: _____ Model: _____

DEVICE DETAILS CONTINUED:

Dependent: ☐ Yes ☐ No Intrinsic Rate and Rhythm: _____

Have there been previous appropriate ICD therapies? ☐ Yes ☐ No

Have there been previous revisions to the pockets or leads? ☐ Yes ☐ No

If yes, please describe:

Will the patient need a new device? ☐ Yes ☐ No

DEVICE INFORMATION:

LEAD	CHAMBER	MODEL #	MANUFACTURER	AGE	COMMENT
1					
2					
3					
4					
5					

ADDITIONAL INFORMATION REQUIRED:

In order to process this referral in a timely manner, please attach the following information:

- ⇒ Current detailed medical history
- ⇒ Medication list
- ⇒ Blood work including CBC, Lytes, BUN, Creatinine, INR and Cultures if applicable
- ⇒ ECHO and/or TEE (required for systemic infection cases)
- ⇒ Device interrogation
- ⇒ 12 Lead ECG

DISPOSITION:

Referring Centre to re-implant? ☐ Yes ☐ No

Extracting Centre to re-implant? ☐ Yes ☐ No If yes, re-implant: ☐ Same device

☐ Consider upgrade to: _____

Patient to be discharged to home? ☐ Yes ☐ No

Patient to be transferred back to Referring Centre for re-implant? ☐ Yes ☐ No

Referring Centre: _____

Accepting MD: _____

ADDITIONAL COMMENTS: