



FOR AFC EDUCATION ONLY PLEASE DIRECT YOUR PATIENT TO:
www.islandhealth.ca/AFC



Atrial Fibrillation Clinic
 Royal Jubilee Hospital
 1952 Bay Street
 Royal Block, 3rd Floor, Rm 343
 Victoria, B.C. V8R 1J8
 Phone: 250-370-8632
 FAX NUMBER: 250-519-1893

Name: _____
 DOB: _____
 PHN: _____
 Telephone number: _____

Date: _____ Referring physician/NP (print & signature) _____

Referred from: Primary care Specialist (specify): _____ MSP# _____
 we do NOT accept referrals directly from Emergency Departments – please refer to GP/NP/UMAC/cardiology

YES ↓ Is there **documentation of atrial fibrillation (AF) or atrial flutter (AFL)?**
 Yes, I am providing compulsory documentation as either a 12-lead ECG, holter report, or rhythm strip

NO ↓ Does the patient have a **reversible cause of AF?**
 e.g. significant electrolyte abnormality, thyrotoxicosis, sepsis (e.g. pneumonia) drug or alcohol use
 If so, please facilitate management of the **reversible** condition before referral to the AF Clinic

NO ↓ **For primary care providers:** does the patient have access to a local **cardiologist? Or internist?**
 Yes, name of MD _____ please refer to existing cardiologist/internist first
 Could your reason for referral be addressed expeditiously via **UMAC** (Urgent Medical Assessment Clinic) or via **RACE** (Rapid Access to Consultative Expertise) at 1-604-696-2131 or RACE-App+?
 Yes, then please refer to the most relevant service to avoid prolonged delays to management

ALL OF THE FOLLOWING TESTING MUST BE REQUISITIONED BEFORE THIS REFERRAL CAN BE PROCESSED:

- Holter monitor within 3 months of referral AND with holter performed on current medication regimen
- ECHO within 12 months AND following diagnosis of AF
- Routine blood work within 3 months including: CBC, electrolytes, renal and liver function testing, and TSH
- OSA screening **IF** high risk result on STOP-BANG questionnaire (<http://stopbang.ca/osa/screening.php>)

FOR PROMPT COMMUNICATION AND ACCESS TO CLINICIAN RESOURCES PLEASE PROVIDE EMAIL ADDRESS:

****PATIENT EMAIL**:** _____
 (patient provided email will imply consent for medical use)

Urgency (*please provide rationale): _____

If the patient has language or cognitive barriers to communication, please provide an alternate contact: _____

Purpose of referral (Check one):

- Anti-arrhythmic and Anticoagulation management plan
- Consideration for Catheter Ablation / EP studies
- Fast-track DC Cardioversion

New diagnosis AF/AFL? YES NO
 If currently in AF/AFL: Resting HR: _____
 Paroxysmal or Persistent (circle one)
 Has OAC been started? YES NO
 see attached CCS CHADS-65 algorithm

Stroke Risk Factors: (check applicable)
 Age >65 Diabetes Hypertension Heart Failure Stroke/TIA

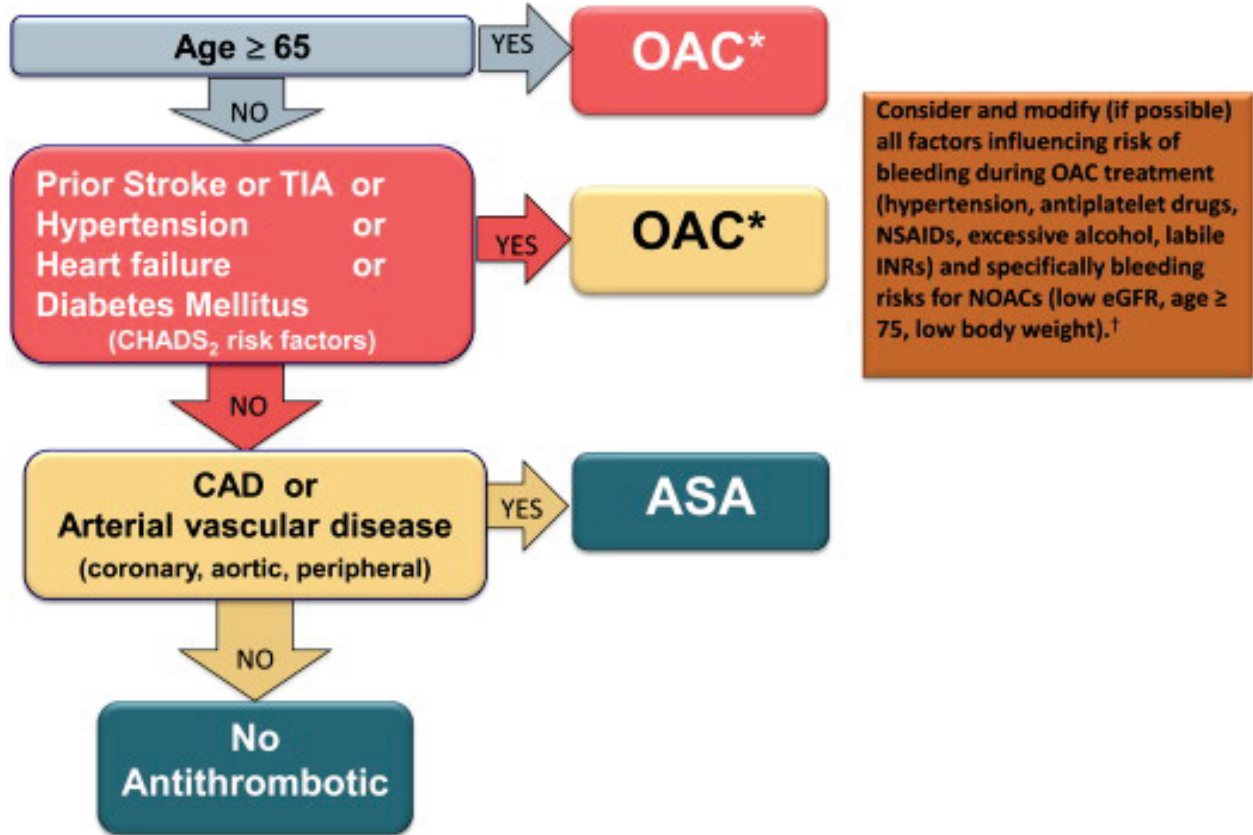
Symptoms when in AF:

AF treatment/cardiac history: (med trials, cardioversions, ablations)



Stroke Risk Assessment

The “CCS Algorithm” for OAC Therapy in AF



<http://www.ccsguidelineprograms.ca>

Definitions

† Might require lower dosing.

AF, atrial fibrillation or atrial flutter; OAC, oral anticoagulant; ASA, acetylsalicylic acid; CAD, coronary artery disease; CCS, Canadian Cardiovascular Society; CHADS₂, Congestive Heart Failure, Hypertension, Age, Diabetes, Stroke/Transient Ischemic Attack; eGFR, estimated glomerular filtration rate; INR, international normalized ratio; NOAC, novel oral anticoagulant; NSAID, nonsteroidal anti-inflammatory drug; TIA, transient ischemic attack. ¹

Reference:

1. Verma A, Cairns J, Mitchell L et al, CCS Atrial Fibrillation Guidelines Committee. 2014 Focused Update of the Canadian Cardiovascular Society Guidelines for the Management of Atrial Fibrillation. Can J Cardiol 2014 Oct;30(10):1114-30. Epub 2014 Aug 13

Accessible from: [http://www.onlinecjc.ca/article/S0828-282X\(14\)01249-5/fulltext](http://www.onlinecjc.ca/article/S0828-282X(14)01249-5/fulltext)

