ATRIAL FIBRILLATION QUALITY CARE PROGRAM REFERRAL

Referring MD: _____ Institution:_____
Billing Number: _____

Booking Information
PLACE PATIENT DEMOGRAPHICS LABEL HERE (Name, DOB, Age, MRN, Address, Contact Phone, Age, Family MD)

Afib History	
□ New onset AFib/ AFL	□ Prior diagnosis of AFib/AFL

Rhythm at time of Referral			
□ AFib	□ AFlutter	□ NSR	□ Paced

Medications at time of Referral		
Antiplatelet	**Anticoagulation**	**Rate Control**
□ Aspirin	□ Warfarin	□ Metoprolol
□ Clopidrogrel	□ Dabigatran	□ Diltiazem
□ Other	□ Rivaroxaban	□ Verapamil
	□ Apixaban	□ Digoxin
	□ Other	□ Other

FAX to Victor at: 416-323-6212 (If any questions, call 416-323-6349)

Did your fax include:

□ Completed referral form?
□ GP consult note
□ Latest Labs?
□ All diagnostic test results (ECG, previous ECHO? Holter? Etc)
□ Did you give the patient the AFQCP One-Page?