

911 Queen's Blvd.,
Kitchener, Ont. N2M 1B2

Health Record # _____	(Insert patient label)
OHIP #: _____	
Patient Name: _____	
DOB: ____ / ____ / ____ Age: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Account: _____ Date of Admission: ____ / ____ / ____	

Left Atrial Appendage Closure Program Referral Form

Please fax to 519-749-6414
Coordinator 519-749-6578, ext. 1992

To request a Consultation for Percutaneous Left Atrial Appendage Closure at WRHN, please fax this form, along with the information noted below, to 519-749-6414.

Patient Address: _____

Patient Preferred Phone Number: _____

Patient Alternate Phone Number: _____

Primary Care Physician Name (if different from referring physician): _____

Reason for Referral: (please check all that apply)

- Patient has Non-Valvular Atrial Fibrillation (NVAF)
- Patient has an increased risk for stroke and is recommended for oral anticoagulation (OAC)
CHADS-VASc score ≥ 3 (See CHADS2-VASc Score table below)
- Patient has an appropriate rationale to seek a non-pharmacologic alternative to OACs
 - History of bleeding or increased bleeding risk (See HAS-BLED table below)
 - Increased bleeding risk not reflected by the HAS-BLED score (eg. thrombocytopenia, cancer, or risk of tumour associated bleeding in case of systemic anticoagulation)
 - Severe renal failure
 - Other situations for which OAC is inappropriate

CHADS2-VASc Score

C	Congestive Heart Failure	1
H	Hypertension (>140/90 mmHg)	1
A	Age >75	2
D	Diabetes Mellitus	1
S2	Prior TIA or stroke	2
V	Vascular disease (MI, aortic plaque, etc.)	1
A	Age 65-74	1
Sc	Sex category (Female = 1 point)	1

Total points: _____

HAS-BLED Score

H	Hypertension	1
A	Abnormal renal/liver function (1 point each)	1 or 2
S	Stroke	1
B	Bleeding history or disposition	1
L	Labile INR	1
E	Elderly (e.g. age > 65 years)	1
D	Current drugs (medication) or alcohol use (1 point each)	1 or 2

Total points: _____

BY SIGNING THIS FORM, I confirm that this patient is aware of this referral.

Referring Physician Name (PRINT): _____

Billing #: _____

Referring Physician Signature _____

Date: ____ / ____ / ____

Phone Number: _____

Fax Number: _____