Soldiers' MEMORIAL HOSPITAL Orillia

Apply Patient Label Here with min. of Name, DOB, Health Card #

Cardioversion Request Form

**Note: Incomplete or illegible forms will be sent back requesting amendment*

Referral Information:

Date Sent	
Referring Clinician	Physician Name (print): _____ Physician Signature: _____ Physician CPSO #: _____
Office Telephone #	
Office Fax #	

Patient Information:

Patient Name	
Patient DOB	
Primary Phone #	
Health Card # & Version Code	
OSMH MRN (if applicable)	
Reason for Request:	
Consult Note attached with pertinent cardiac history:	Yes ☐ or No ☐
Physician's Orders completed, attached and signed	Yes ☐ or No ☐

For P.A.C Use Only

Date & Time for Cardioversion: _____

☐ Cardioversion Team Notified

☐ Case Anesthetist Notified