

Atrial Fibrillation Quality Care Program (AFQCP) Referrals

Appointment Date:	Time:	
Referring MD:	Billing	#:
Patient Booking Information:		
ED Visit Date: (day/month/year):		
AFib History:		
☐ New Onset AFib / AFL ☐ Prior Diagnosis of AFib / AFL		
Medications Prescribed at ED Discharge: Antiplatelet Anticoagulation Rate Control		
☐ Aspirin	□ Warfarin	□ Metroprolol
☐ Clopidrogel	□ Dabigatran	□ Dilitiazem
□ Other	□ Rivaroxaban	□ Verapamil
	□ Apixaban	□ Digoxin
	□ Edoxaban	□ Other
Fax to: 416-323-6212	For questions:	416-323-6349
This section to be completed by ED Ward Clerk: Did you:		
☐ Fill in appointment date / Time on appointment page		
☐ Ensure patient has Patient Handout		
□ Include ED note, ECGs and latest labs with referral form?		
□ Fax everything to: 416-323-6212		

ED Ward Clerk Initials ____