

Arrhythmia Assessment Unit

Prompt & Comprehensive Assessment
for Patients with New Onset Atrial Fibrillation



Patient Referral Criteria

First Detected AF

- Irregular pulse noted during routine examination and/or confirmation ECG.

Symptomatic Presentation

- Clinical suspicion of AF.

Paroxysmal / Persistent

- Patient to attend fasting if on-set of symptoms is less than 48 hours.

Previously diagnosed AF

- May be seen in Cardiology Clinics.

Referral Process

GP referral letter is required.

Urgent Arrhythmia

- Contact Arrhythmia Nurse for immediate access 01 885 8888 (ask for bleep 8407).
- Same day assessment organised if required.

Non-Urgent Arrhythmia

- Contact Cardiology Outpatient Appointments 1800 200 550.
- Post or fax referral letter specifying Arrhythmia Service.
- Assessment within 1 week of referral.

Services Provided

- Resting ECG.
- Physical examination and clinical history.
- TFT's, FBC, electrolytes if appropriate.
- Holter monitor, event monitor, echocardiogram as required.
- Review of patient by Consultant Cardiologist / Electrophysiologist.
- Referral to Cardiology Nurse Specialist for Warfarin education as required.
- Immediate Cardioversion.
- Antiarrhythmic drug therapy.
- Possible subsequent Pulmonary Vein Isolation (Ablation) as appropriate.

Arrhythmia Assessment Unit

Mater Private Hospital
Eccles St, Dublin 7

Routine Referrals

Mon – Fri: 8am – 6pm
Freephone: 1800 200 550
Fax: 01-885 8150

Urgent Referrals

Mon – Fri: 8am – 8pm
Tel: -01 885 8888 bleep
8407 (Chest Pain Nurse)
Fax: 01-885 8150



Arrhythmia Assessment Unit

Referral Form



Practice Details

GP Name: _____

Address: _____

Tel: _____

Fax: _____

Referring GP Signature: _____

Patient Details

Name: _____

Address: _____

Tel: _____

Mobile: _____

Date of Referral: _____

Patient History

Reason for Referral: _____

Current Medication: _____

Please include the following information if known:

INR: _____ Date Taken: _____

TFT's: _____ Date Taken: _____

Electrolytes: _____ Date Taken: _____

FBC: _____ Date Taken: _____

ECG: _____ Date Taken: _____

Past Medical History / Additional Information (Details of any previous history. Record & include when patient symptomatic if possible):

MPH 14404 v1_0810

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