Heart Function Clinic Referral Form

BC's HEART FAILURE NETWORK
Quality care for quality life.

Health Authority Logo

*** Key Elements***

***Patient**	***Referring Provider**
Name _____	Name _____
Address _____	Phone _____
City_____	Fax # _____
Province_____	MSP # _____
Contact # _____	☐ GP , ☐ NP, ☐ ED ☐ In patient
PHN #_____	☐ ☐ Specialist Specify _____
DOB	

***Reason For Referral**	***Care Management**
☐ Assessment of ASYMPTOMATIC heart failure (HF) ☐ Chronic heart failure management ☐ Heart Failure with symptoms but Not decompensated, ☐ New diagnosis of heart failure and STABLE ☐ New diagnosis of heart failure and UNSTABLE o Post MI heart failure; hospitalization HF; worsening HF	☐ Shared care: (GP and Clinic physician/NP) ☐ HF physician/NP to stabilize and optimize medication therapy ☐ Optimize patient self-management/ education ONLY ☐ Advice only on care management **Additional health care professional who needs to be CC'd** Name _____ Address _____ Fax # _____

***Specific question referring provider would like answered?**

***Primary Language Spoken If not English please ensure there is someone with the patient who can speak English**

*** Please include/or attach a complete list of all medications your patient is taking**

***Co-morbidities:**

☐ Diabetes, ☐ Renal ☐ Hypertension ☐ Angina ☐ Thyroid Disease ☐ Respiratory

☐ Arrhythmias ☐ CABG ☐ TIA/CVA ☐ Arthritis ☐ Malignancy ☐ Other specify _____

*Please **attach available/relevant cardiac investigation results**

For example: Echo, MIBI, MUGA, ECG, Angiogram, CXR, consultation notes, Blood work (BNP, Lytes, etc.)

***Acknowledgement of Referral (Will be completed by HFC staff)**

☐ Our office will make an appointment with the heart function DR/NP in the next _____Week (s)
☐ Your patient is booked to be seen by the heart function ***Nurse*** on _____
☐ We require additional information _____
- o Before we can book the patient
- o Prior to the patient's appointment

***Referring Physician/ NP _____ *Date: _____**
# of pages faxed_____

***Fax to: ADD Health Authority Fax #**

To expedite care PLEASE ensure ALL aspects of this form are completed