Heart Failure Clinic
St. Joseph's Hospital
268 Grosvenor St.
London, ON N6A 4V2
Fax: 519-646-6219

HEART FAILURE CLINIC REFERRAL FORM

Please complete all **FOUR** sections, **ATTACH** all related documents and **FAX** to the Heart Failure Clinic at **519-646-6219**

1. PATIENT INFORMATION Affix LABEL or complete:

Name: _____ J#/PIN: _____

Gender: M / F Date of Birth: _____ (YYYY/MM/DD)

Health Card#: _____

Telephone #: _____

Family Physician: _____

Language Spoken: _____

2. REFERRING HEALTHCARE PROVIDER

Name: _____

Telephone # _____

Fax # _____

Date of Referral _____

Pick only **ONE** primary referral reason: ❑ **HFpEF ≥50%** ❑ **HFmEF 41-49%** ☐ **HFrEF ≤40%**

3. MANDATORY - PRIMARY REFERRAL CRITERIA – Patients must meet one of the following criteria (Check A, B, C, or D):

Priority will be given to patients meeting criteria A & B

Patients meeting criteria C & D will be considered on an individual basis

A. Minimum two (2) hospital admissions for heart failure **(primary diagnosis)** within the past six (6) months.

Admission Dates:

1) _____

2) _____

B. Minimum two (2) ER visits within the past two (2) months for heart failure requiring IV Lasix (furosemide).

ER Dates:

1) _____

2) _____

C. NYHA Class III-IV heart failure symptoms despite best attempts to optimize diuretics and medical therapy.

D. Patients with advanced HF requiring frequent visits to clinic due to high risk markers for hospital admission.

4. PATIENT / TREATMENT HISTORY AND INVESTIGATIONS:

Brief History:

LVEF:
☐ <20% ☐ 20-39% ☐ 40-49% ☐ ≥50%

	NO	YES
Previous CABG	☐	☐
Previous PCI/Stent	☐	☐
Previous Valve Surgery	☐	☐
ICD / CRT present	☐	☐

Comorbidity Assessment:

	NO	YES
CKI (Crt ≥200) or Dialysis	☐	☐
Diabetes. If Yes, ☐ Insulin ☐ Oral Agent ☐ Diet	☐	☐
Smoking History	☐	☐
Hypertension	☐	☐
Previous MI	☐	☐
History of Atrial Fib/ Flutter	☐	☐
PVD/ Stroke	☐	☐
Severe COPD / Pulmonary HTN	☐	☐
History of Valvular Heart Disease	☐	☐
Permanent Pacemaker (PPM)	☐	☐
Hx of ETOH/ Drug Abuse	☐	☐
Social Issues	☐	☐

Supporting Documents:

Send copies of the following if not available on Powerchart:

- ☐ Consultation note(s)
- ☐ Discharge notes
- ☐ Recent laboratory investigations including: CBC, Electrolytes, BUN, Creatinine, AST, ALP, ALT, Total Bilirubin and Albumin, Lipid Profile,
- ☐ 2D echo completed within the past 6 months
- ☐ Chest x-ray report and ECG
- ☐ Most responsible referring provider (MRP)

Additional Notes: _____

Please ensure contact information is current. Thank you for your referral!