Heart Failure Clinic
St. Joseph's Hospital
268 Grosvenor St.
London, ON N6A 4V2
Tel: 519-646-6000 ext. 61700

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: _____

2. REFERRING PHYSICIAN

Please print or use a stamp:

Name: _____

Telephone # _____

Fax # _____

Address: _____

_____

Pick only **ONE** primary referral reason

☐ **HFrEF < 45%** ☐ **HFpEF > 45%** ☐ **Pulmonary Hypertension** (RVSP > 50 mmHG and symptomatic dyspnea)

3. MANDATORY - PRIMARY REFERRAL CRITERIA –

Patients must meet one of the following criteria (Check A, B, C, D, or E)**:**

☐ **A.** At least <u>two</u> hospital admissions <u>for heart failure (Primary diagnosis)</u> within the past six (6) months. Admission Date: (1) _____ (2) _____	☐ **B.** Minimum two (2) visits over a two (2) month period to ER requiring IV Furosemide	☐ **C.** AHA Stage C/D, NYHA Class III-IV CHF Symptoms despite best attempts to optimize medical therapy	**D.** Patients will be considered on an individual basis if they are felt to have advanced HF requiring frequent visits to clinic due to high risk markers for hospital admission and /or the need for palliative ("symptom management") care.

4. PATIENT / TREATMENT HISTORY AND INVESTIGATIONS:

Brief History:

EF: ☐ <20% ☐ 20-39% ☐ 40-59% ☐ >60%

	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 Ht	☐	☐
History of Valvular Heart Disease	☐	☐
Permanent Pacemaker (PPM)	☐	☐
Hx of ETOH/ Drug Abuse	☐	☐
Social Issues	☐	☐

Supporting Documents:

☐ **See Powerchart or Clinical Connect** Send copies of the following **if not available on Powerchart or Clinical Connect**

- ☐ 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

Additional Notes: _____

_____ ***Date:_____Thank you for your referral!***