Heart Failure Clinic - Huron Perth
107-444 Douro St. Stratford, ON N5A 0E6
Phone: 519-273-0100 Fax: 519-273-0675

HEART FAILURE CLINIC REFERRAL FORM

Please complete all **FOUR** sections, **ATTACH** all related documents, and **FAX** to the Heart Failure Clinic

1. PATIENT INFORMATION
Name: ___________________________
Date of Birth: ___________(YYYY/MM/DD)
Health Card #: _____________________
Address: __________________________
Telephone #: ______________________
Alternate #: ______________________

2. REFERRING PHYSICIAN
Name: ___________________________
Telephone #: ______________________
Fax #: ___________________________
Billing #: _________________________
Family Physician: __________________

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

☐ **A.** Urgent consult request to be seen in 1 week
- Known heart failure with decompensation

☐ **B.** Consult requested
- Known heart failure
- NYHA class ______

☐ **C.** Consult requested
- Suspected heart failure

Clinical history:

☐ shortness of breath
☐ PND
☐ peripheral edema

4. PATIENT/TREATMENT HISTORY AND INVESTIGATIONS:

Cardiac History & Investigations:
(attach if available)

Echo ☐Yes ☐Pending
EF: ☐<20% ☐20-39% ☐40-59% ☐>60%

☐ ECG or holter
☐ Previous CABG
☐ Previous PCI/Stent
☐ Previous Valve Surgery
☐ ICD: CRT present
☐ Previous stress test

Comorbidity Assessment:

☐ CKD (Crt ≥200) or Dialysis
☐ Previous MI
☐ History of Atrial Fib/Flutter
☐ PVD/Stroke
☐ Severe COPD/Pulmonary Ht
☐ History of Valvular Heart Dis
☐ Hx of ETOH/Drug Abuse

Supporting Documents:

Please send copies of:

☐ Consultation note(s)/med list
☐ Discharge notes
☐ Recent laboratory investigations including: CBC, Electrolytes, Creatinine,ALP, ALT, Total Bilirubin and Albumin, Lipid Profile
☐ 2D echo
☐ Chest x-ray report and ECG

Additional Notes:

Date: ___________________________ **Thank you for your referral.**

To ensure patient safety while balancing timely access, please follow and manage newly arranged tests until patient is seen by the Heart Failure Clinic. Please copy arranged tests to the Heart Failure Clinic. **We shall prioritize seeing the patient in their home community as capacity allows.