

Heart Failure Referral Form

NOTE: Please go to http://ccs.ca/guidelines/cc_library_e.aspx for all Canadian Cardiovascular Society Heart Failure Guidelines

REFERRING PHYSICIAN

Place physician stamp here (if available)

Patient's regular family physician? Yes
No

↓
Contact details (if known):

Billing number:

PATIENT DEMOGRAPHICS

Surname:

First name:

DOB:

Health number:

Address:

(H):

(B):

Ext.

(C):

REASON FOR REFERRAL

Referral date:

Arrange investigations for further diagnostics

New heart failure diagnosis*

Unresponsive to treatment

Worsening symptoms

Other:

If emergent call cardiologist or go to ER

Urgent (< 2 weeks)

Non-urgent (< 6 weeks)

Refer to CCS waittime benchmarks

http://www.ccs.ca/download/position_statements/CCS_Atlas_for_CCS.pdf

HISTORY

Chronic kidney disease

Angina

Diabetes

MI

Smoker

Hypertension

COPD

Recent syncope

NYHA class

<http://sscts.org/ClassificationHeartFailureNYHA.aspx>
(check one)

1

2

3

4

Pertinent cardiovascular history:

(*Include relevant family history if first time with these symptoms)



PHYSICAL EXAMINATION

Weight: _____ Height: _____ Blood pressure: _____ / _____ Heart rate: _____

Recent increase in edema/weight? Yes No

Other relevant physical findings:

MEDICATIONS

Current medication list: Attached Adherence to medications? Yes

No

Drug allergies/intolerance details:

LAB TESTS

Hb Creatinine/eGFR K+ Fasting glucose

Other pertinent lab results:
(e.g., TSH, liver enzymes)

DIAGNOSTIC IMAGING

The following must be provided by referring physician:
(tick boxes below when completed)

Chest X-Ray

ECG

Attached

IF KNOWN:

Echo or MUGA *

Brain Natriuretic Peptide (BNP)

Coronary Angiogram

Holter

* Consultant will arrange as appropriate prior to consult

Comments/other relevant medical history:

PLEASE NOTE: If there is a change in status or new diagnostic information becomes available, notify consultant.

CONSULTANT RESPONSE

Appointment date: _____ Patient has been notified Yes No

Place physician stamp here (if available)

Copy to family physician if not the referring physician

Consultant name: _____ Signature: _____ Date: _____