FAX NUMBER _____ **NUMBER OF PAGES** _____

Heart Failure Referral Form

NOTE: Please go to **http://ccs.ca/index.php/en/guidelines/guidelines-library** 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 wait-time benchmarks

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

HISTORY

- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Smoker
- ☐ COPD
- ☐ Angina
- ☐ MI
- ☐ Hypertension
- ☐ 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: _____