North Bay Regional Health Centre

Cardiac Respiratory Services
Heart Failure Clinic Referral Form

Please complete all FOUR sections. ATTACH all related documents, and FAX form to 705-495-8116

1.PATIENT INFORMATION	**2: REFERRING PHYSICIAN**
Name:_____ Date of Birth: _____ (YYYY/MM/DD) Health Card #: _____ Address: _____ Telephone #:_____ Alternate #: _____ Family Physician: _____	Name: _____ Telephone #: _____ Fax #: _____ Address: _____

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

☐ A. **Urgent Consult** requested	☐ B. Consult requested	☐ C. Routine Consult requested
-Recent hospital admission or ER visit for heart failure (primary diagnosis) -Known heart failure with decompensation -New diagnosis of heart failure, not improving on therapy	-Known Heart failure, -NYHA class _____ -New diagnosis of heart failure, stable, compensated	-Chronic heart failure disease management -NYHA I/II -Uncertain of heart failure etiology

4. PATIENT/TREATMENT HISTORY AND INVESTIGATIONS:

Cardiac History & Investigations: (attach if available)	**Comorbidity Assessment:**	**Supporting documents:**
Echo: ☐ Yes ☐ Pending EF: ☐ <20% ☐ 20-39% ☐ 40-59% ☐ >60% ☐ Previous CABG ☐ Previous PCI/Stent ☐ Previous valve Surgery ☐ ICD: CRT present ☐ Previous stress test ☐ ECG or holter	☐ CKD (Crt ≥ 200) or dialysis ☐ Previous MI ☐ History of Atrial fib/flutter ☐ PVD/ Stroke ☐ Severe COPD/ Pulmonary Ht ☐ History of valvular Heart Disease ☐ Hx of ETOH / drug abuse ☐ Hypertension ☐ Smoking history	☐ Consultation note(s) ☐ Discharge notes ☐ Recent laboratory investigations including: CBC, electrolytes, Urea, Creat/eGFR, ALP, ALT, Bilirubin and Albumin, Lipid profile ☐ 2D echo ☐ Chest x-ray and ECG

Heart Failure Clinic Use Only Priority code: ☐1 ☐2 ☐3 Triage by(initials):_____

Date: _____ Physician Signature: _____

Physician Print Name: _____