



HEALTH CARE

St. Paul's Hospital

1081 Burrard Street, Vancouver, B.C. V6Z 1Y6
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HEART FUNCTION CLINIC REFERRAL FORM

Name: _____

Date of birth: _____ M / F _____

PHN: _____

Address: _____

_____ P.C.

Phone: _____

Referring Doctor: _____ Billing #: _____ Date Referred: _____

Number of pages including this one: _____

- Assessment of ASYMPTOMATIC Heart Failure
- Chronic heart failure management
- Heart failure with symptoms but NOT decompensated, **OR**
New diagnosis of heart failure and STABLE
- New diagnosis of heart failure and UNSTABLE **OR**
Post MI heart failure **OR**
Post hospitalization heart failure **OR**
Progressively worsening heart failure
- Heart transplant assessment

- CLINIC PATHWAY SELECTION (check one):**
- Assessment and optimization of HF therapy – clinic team to perform uptitration of medication
 - Assessment and optimization of HF therapy – Referring physician to perform uptitration with clinic support
 - Self-management teaching **only** – Pt to attend 3 teaching sessions. Pt will **not** be seen by a Cardiologist

Interpreter Needed: Yes No Specify language: _____

Does patient know about; and agree to the referral? Yes No

Please complete the following checklist and attach all reports.

	DONE (Please include report)	NOT DONE		DONE	NOT DONE
CHEST XRAY			CARDIAC CT		
ECHOCARDIOGRAM			CARDIAC MRI		
RIGHT HEART CATH REPORT			CONSULT NOTES		
CORONARY ANGIOGRAM REPORT (INCLUDE HEARTVIEW DIAGRAM)			PLEASE ATTACH A LIST OF CURRENT MEDICATIONS AND RELEVANT HISTORY		

Acknowledgement of Referral within 48 hours (to be completed by specialist clinic)

- Our office will make the appointment with your patient within the next _____ week(s)
- Your patient is booked to see a specialist on _____
 - Please notify your patient of the above appointment
 - We will notify your patient of the above appointment
- Attached is additional information for you to give to your patient

We require additional information before we can book the patient prior to the patient's appointment