



HEALTH CARE

St. Paul's Hospital

1081 Burrard Street, Vancouver, B.C. V6Z 1Y6
Ph: 604-806-8733 Fax: 604-806-8763

HEART FUNCTION CLINIC REFERRAL FORM

Name: _____

Date of birth: _____ M / F _____

PHN: _____

Address: _____

_____ P.C.

Phone: _____

Number of Pages including this one: _____

PLEASE NOTE: Incomplete referrals **WILL BE RETURNED UNPROCESSED**. Please complete the **entire** form.

- 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

Comments:

Referring Doctor: _____

Interpreter Needed: Yes No Specify language: _____

Please complete the following checklist and attach reports for all items checked "Done":

	DONE (Please include report)	NOT DONE	COMMENTS
CHEST XRAY			
ECHOCARDIOGRAM			
RIGHT HEART CATH REPORT			
CORONARY ANGIOGRAM REPORT (INCLUDE HEARTVIEW DIAGRAM)			
CARDIAC CT SCANS			
CARDIAC MRI SCAN			
OTHER CARDIAC DIAGNOSTIC TESTS			
RELEVANT CONSULT NOTES			

***** Please include a complete list of current medications*****

Physician Signature: _____ Date Referred: _____

If the form is complete, we will contact the patient directly to make an appointment.