St.Mary's
REGIONAL CARDIAC CARE CENTRE
Phone: 519-749-6919
Fax: 519-749-6785

Last Name First Name

Address

Home Phone Date of Birth (DD/MM/YY)

HEART FUNCTION CLINIC REFERRAL FORM

Please send copies of the following information with every referral:

❑Consultation Note
❑Recent laboratory investigations including: CBC, Electrolytes, BUN, Creatinine, AST, ALP, ALT, Total Bilirubin and Albumin, Lipid Profile
❑2D echo completed within the past 6 months
❑Chest x-ray report and ECG

Referral Criteria: Patients must meet the following criteria

1) At least two hospital visits for heart failure within the last year:
   Dates:_____
2) NYHA Class III-IV CHF

Patients will be considered on an individual basis if they have had one admission for heart failure within the last year and meet one or more of the following criteria: (check all that apply)

❑Sub-optimal drug therapy
❑Advanced heart failure (i.e. recurrent ER visits and/or frequent hospital admissions for heart failure)

BRIEF HISTORY:	**COMORBIDITY ASSESSMENT:**
	NO **YES**
	❑ ❑ Dialysis
	❑ ❑ Diabetes
	If yes, ❑ Insulin ❑ Oral Agent ❑ Diet
	❑ ❑ Smoking History
	❑ ❑ Hypertension
	❑ ❑ Hyperlipidemia
	❑ ❑ Severe Carotid Stenosis
	❑ ❑ PVD
	❑ ❑ Severe COPD
	Current Medications:
EF: ❑<20% ❑ 20-39% ❑ 40-59% ❑ >60%	_____
PREVIOUS BYPASS: ❑No ❑Yes	_____
PREVIOUS PTCA: ❑No ❑Yes	_____
	_____
Fax Form/Information to 519-749-6785	

Referring Physician: _____ Date: _____
Print Name

_____
Signature

☐ **Consult only** ☐ **Consult and ongoing management**