

Heart Failure Referral Form



Canadian Cardiovascular Society
Leadership. Knowledge. Community.

Société canadienne de cardiologie
Communauté. Connaissances. Leadership.

NOTE: Please go to www.ccs.ca for all Canadian Cardiovascular Society Heart Failure Guidelines

Place physician stamp here (or provide contact details)

Patient's regular family physician? Yes

↓
Contact details (if known): No

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 waittime benchmarks www.ccs.ca

HISTORY

Chronic kidney disease

Angina

Diabetes

MI

Smoker

Hypertension

COPD

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
Faxed separately 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)

Attached Faxed separately

Chest X-Ray

ECG

IF KNOWN:

Echo or MUGA*	Coronary angiogram
Brain Natriuretic Peptide (BNP)	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 Place physician stamp here (or provide contact details)
No
Copy to family physician if not the referring physician

Preliminary recommendations:

Consultant name: _____ Signature: _____ Date: _____