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)

Billing number: _____

Patient's regular family physician? ☐ Yes ☐ No

Contact details (if known):

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 wait-time benchmarks www.ccs.ca

HISTORY

☐ Chronic kidney disease
☐ Diabetes
☐ Smoker
☐ COPD
☐ Angina
☐ MI
☐ Hypertension
☐ 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 ☐ Faxed separately

Adherence to medications? ☐ Yes ☐ 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*

☐ Brain Natriuretic Peptide (BNP)

☐ Coronary angiogram

☐ 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 ☐ No

Place physician stamp here (or provide contact details)

Copy to family physician if not the referring physician ☐

Preliminary recommendations:

Consultant name: _____ Signature: _____ Date: _____