RVH
Royal Victoria
Regional Health Centre

Heart Function Clinic Requisition

201 Georgian Drive, Barrie, Ontario
Phone: 705-728-9090 x 23336
Fax: 705-728-3039

PATIENT NAME: _____

DOB: _____

HRN: _____

(addressograph)

Patient Information

Patient Name: _____ Gender: _____

Address: _____ Postal Code: _____

Referring MD: _____ Family MD: _____ Physician Signature: _____

List the patient's home phone number, and if applicable, one alternate number. For each number, use the tick boxes to indicate if the patient consents to be called at that number and/or if messages relating to his/her care & appointments can be left at that number:

Home:	☐ Call – can leave a message	☐ on voicemail	☐ with a person
Work/Other:	☐ Call – can leave a message	☐ on voicemail	☐ with a person

Primary Indication for Heart Function Clinic Referral:

☐ New diagnosis of heart failure ☐ Heart failure with symptoms ☐ Chronic heart failure management
☐ Self-management education only ☐ Other:

Etiology of Heart Failure:

☐ CAD ☐ Hypertension ☐ Cardiomyopathy ☐ Valvular Disease ☐ Congenital Disease
☐ Other:

Treatment Completed:

☐ Valve replacement ☐ Prior PCI ☐ Hypertension controlled ☐ Prior Pacemaker or ICD
☐ Prior Coronary Bypass ☐ Other:

NYHA Functional Class: _____	Most current LV systolic function: Grade _____ or EF _____%

Diagnostic Workup: Indicate which tests were completed and attach results with referral

☐ Echocardiogram ☐ MUGA ☐ Stress Test ☐ Myoview Nuclear Test ☐ Coronary Angiogram ☐ CT
☐ Electrolytes ☐ CBC ☐ Creatinine ☐ ECG ☐ CXR ☐ BNP ☐ LFT's ☐ TSH

Relevant Clinical Information *Must be provided and please be specific. Please attach a list of all medications*

BY SIGNING THIS REQUISTION, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referring Physician:	Signature:	
Telephone Number:	Fax Number:	Billing #: