Heart Function Clinic Referral

Phone: 705-739-5604 ext 5
Fax: 705-739-5651

PATIENT NAME: ______________________________

DOB: ____________________ Gender: __________

Address: ______________________________

HRN: ____________________

(Patient Label)

Preferred Site: ☐ **BARRIE – 201 Georgian Drive** ☐ **INNISFIL – 7325 Yonge Street, Suite 1600**

Referral Information

Referring MD/NP: __________________ Primary care provider: _________________ Date: _______________
Community Cardiologist? ☐ No ☐ Yes Specify: _________________________________

Patient's Phone Number: ____________ Alternate Contact: _________________ Phone Number: ______________

Translator required? ☐ No ☐ Yes Specify: _________________________________

Referral Criteria

Patient must have documented ejection fraction (EF) or radiographically proven heart failure (HF) and one of the following (check which one applies):

- ☐ Persistent NYHA 3-4 symptoms; or
- ☐ NYHA 2+ symptoms with at least 2 hospital admissions or emergency room (ER) visits for HF in the past year; or
- ☐ NYHA 2+ symptoms and 1 hospital admission or ER visit for HF and with a significant comorbidity (e.g. chronic kidney disease, arrhythmia, chronic obstructive lung disease, sleep apnea, diabetes, frailty, anemia); or
- ☐ Special request by Internal Medicine or Cardiologist for advanced HF or complex cases, please specify: _________________________________

Type / Etiology of Heart Failure

- ☐ Heart failure with reduced ejection fraction (HFrEF), EF equal or less than 40%
- ☐ Heart failure with preserved ejection fraction (HFpEF), EF greater than 50%
- ☐ Heart failure with mid range ejection fraction (HFmrEF), EF 41-50%
- ☐ Other: ____________________________

Reason for Referral

Requested Documentation (check what is enclosed)

- Consultation Note
- Discharge Summary
- Angiogram/PCI/Surgical report
- Echocardiogram
- Cardiac MRI
- MUGA
- Laboratory results
  - BNP / nt-pro-BNP____
- Other: ____________________

Failure to provide the requested information may result in unnecessary delays in scheduling and assessment

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

Referring Provider:	Signature:

Telephone Number:	Fax:	Billing #: