northern health
the northern way of caring

BC's HEART FAILURE NETWORK
Quality care for quality life.

NORTH
Network of Rural to Tertiary Healthcare

Heart Function Clinic Referral Form

Fax: 1-855-565-5630

*A. Patient information

Name: _____

Address: _____

_____

Phone (H): _____ (C): _____

PHN: _____

DOB: _____

*B. Referring provider

Name: _____

Phone: _____

Fax: _____

MSP: _____

☐ GP ☐ NP ☐ ED ☐ Primary Care Home ☐ Specialist

☐ NH facility: _____

*C. Reason for referral

Please select the appropriate reasons:

☐ Assessment of etiology of heart failure (HF)
☐ Assessment of **asyptomatic HF**
☐ Chronic heart failure management
☐ Chronic HF with symptoms/**stable**
☐ Chronic HF with symptoms/**unstable**
☐ New diagnosis of heart failure/**stable**
☐ New diagnosis of heart failure/**unstable**
☐ Assessment for device (pacemaker/ICD)
☐ Other: _____

*D. Care management request

Please select one of the following:

☐ Shared care (referring GP/NP and clinic staff)
☐ HF clinician to stabilize and optimize medication therapy
☐ Advice only on care management
• Optimize patient self management/education
Self management/education is included with shared care and medication therapy requests

Additional health care professional to be copied:

Name: _____

Address: _____

Fax: _____

E. Specific question to be addressed (attach summary of patient medical history, recent cardiac consultation or discharge summary for shared care or medication optimization only request):

_____

_____

_____

_____

F. Barriers to access (social determinants, language, etc): _____

_____

*G. Please attach a complete list of all medications your patient is taking (not needed for education referral)

H. Co-morbidities (not needed for education referral)

☐ Hypertension ☐ TIA/CVA ☐ Valvular heart disease ☐ Diabetes ☐ Malignancy ☐ CABG
☐ CAD ☐ Arrhythmias ☐ Thyroid disease ☐ Renal ☐ Respiratory

☐ Other: _____

I. Please attach recent (tests done within 6 to 8 weeks) available/relevant cardiac investigation results

(* are mandatory for shared care or medication optimization requests only)

Investigations: ECG*, CXR*, Echo, MIBI, MUGA, Angiogram,
Labs*: CBC, Lytes, Creatinine, GFR, TSH, Lipids, BNP

***Referring MD/NP signature:** _____ ***Date:** _____

***Fax to: 1-855-565-5630**
(*mandatory)

To expedite care please ensure all aspects of form are completed