Heart Failure Clinic
North Lambton Community Health Centre

Referral to: **Heart Failure Clinic**

Affix label or complete:

Name:	DOB:
Address:	City:
Postal Code:	Health Card #:
Telephone:	Primary Care Provider:

Role of the Clinic:

For patients exhibiting heart failure NYHA Class III-IV symptoms despite attempts to optimize therapy with the goals of:

a. improving symptoms and quality of life
b. optimization of HF care
c. decreasing hospital admissions

Referring Clinician

○ Family physician	○ Cardiologist	○ Internist
○ Nurse practitioner	○ Cardiac surgeon	○ Other: _____

Point of Referral

○ Emergency	○ Cardiac diagnostics	○ Primary Care
○ Outpatient clinic	○ Inpatient unit	○ Other: _____

Please fax the following with completed referral form: • pertinent discharge summaries • consult notes and reports • cardiac investigations (ECG, echo, etc)	• recent lab investigations • latest medication list

Brief History:

_____ _____ _____

Referring MD/NP (please print) Signature Date

Cardio-Pulmonary Rehabilitation, 460 Christina Street North, Unit 10, Sarnia, ON, N7T 5W4
Phone: 519-491-2123; Fax: 519-491-6575