



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	<input type="radio"/> Family physician	<input type="radio"/> Cardiologist	<input type="radio"/> Internist
	<input type="radio"/> Nurse practitioner	<input type="radio"/> Cardiac surgeon	<input type="radio"/> Other: _____

Point of Referral	<input type="radio"/> Emergency	<input type="radio"/> Cardiac diagnostics	<input type="radio"/> Primary Care
	<input type="radio"/> Outpatient clinic	<input type="radio"/> Inpatient unit	<input type="radio"/> 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