St.Mary's
REGIONAL CARDIAC CARE CENTRE

Phone: 519-749-6919
Fax: 519-749-6785

Last Name First Name

Address

Phone Date of Birth (D/M/Y)

ST. MARY'S HEART FUNCTION CLINIC REFERRAL FORM

Please send copies of the following information with every referral:

- ☐ Admission/Discharge Note
- ☐ Chest X-ray Report and ECG
- ☐ 2D echo completed within the past 6 months
- ☐ Specialty Consult Notes

Referral Criteria - patients must meet the following criteria:

- ☐ At least two hospital visits for heart failure within the last year (dates required): _____
- ☐ NYHA Class III-IV CHF

Patients will be considered on an individual basis if they have had one admission for heart failure within the last year and meet one or more of the following criteria: (check all that apply)

- ☐ Advanced heart failure (i.e. recurrent ER visits and/or frequent hospital admissions for heart failure)
- ☐ Sub-optimal drug therapy

REASON for REFERRAL:	**CURRENT MEDICATIONS**
EF: ☐ <20% ☐ 20-39% ☐ 40-59% ☐ >60% **NYHA class** 1 / 2 / 3 / 4	

REFERRAL DATE (D/M/Y):_____

REFERRING PHYSICIAN INFORMATION:
NAME (PRINT):_____
ADDRESS:_____
TEL:_____
FAX:_____
SIGNATURE:

HFC USE ONLY
Reviewed: MD_____ Date_____
Accepted: Follow-Up Timing_____
Declined: Referral to HFMU Clinic_____
Cardiologist_____Other_____

FAMILY PHYSICIAN
NAME:_____
ADDRESS:_____
TEL:_____
FAX:_____

COMMUNITY CARDIOLOGIST
NAME:_____
ADDRESS:_____
TEL:_____
FAX:_____