



HEART FUNCTION CLINIC REFERRAL

JIM PATTISON OUTPATIENT CARE & SURGERY CENTRE



CDXX104705A

Apr 14/11

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JPOCSC 9750 140th Street Surrey, B.C. V3T 0G9**Phone: (604) 582-4584****Fax: (604) 582-4590**
Patient's Full Legal Name: _____
Last First Middle
Other Name(s) (if applicable): _____

Personal Health Number: _____ **Date of Birth:** ____/____/____ **Gender:** M F
(DD, MM, YYYY)
Address: _____
Street City Province Postal Code
Home Phone No. _____ Okay to Call **Message Phone No.** _____

Insurance Type MSP WCB Out-of-Province Self-Pay **Other:** _____ RCMP or Armed Forces #: _____

Interpreter Required: No Yes **Language:** _____
REASON FOR REFERRAL:

- Assessment of ASYMPTOMATIC heart failure
- Chronic heart failure management
- Heart failure with symptoms but Not decompensated.
- New diagnosis of heart failure and STABLE
- New diagnosis of heart failure and UNSTABLE
- Post MI heart failure; hospitalization HF; worsening HF

CARE MANAGEMENT:

- Shared care: (GP and Clinic physician/NP)
- HF physician/NP to stabilize and optimize medication therapy
- Optimize pt self management/education ONLY
- Advice only on care management

Specific question referring provider would like answered?
Co-morbidities:

- Diabetes Renal Hypertension Angina Thyroid Disease Respiratory
- Arrhythmias CABG TIA Arthritis Malignancy Other specify _____

Please include/or attach a complete list of all medications your patient is taking.
Please attach available/relevant cardiac investigation results

For example: Echo, MIBI, MUGA, ECG, Angiogram, CXR, consultation notes, Blood work (BNP, Lytes, etc)

Acknowledgement of Referral (will be completed by HFC staff)

- Our office will make an appointment with the heart function DR/NP in the next _____ week(s)
- Your patient is booked to be seen by the heart function **Nurse** on _____
- We require additional information _____
 - Before we can book the patient
 - Prior to the pts appointment

Additional health care professional who needs to be CC'd
 Name _____ Fax _____
 Address _____

To expedite care PLEASE ensure ALL aspects of this form are completed
Family Physician (if different from referring source)
 Name: _____
 MSP #: _____
 Phone: _____ Fax: _____
 Patient has no GP/NP
Referring Health Care Provider:
 Name: _____
 MSP #: _____
 Phone: _____ Fax: _____
 GP NP ED Inpatient physician/NP Specialist Physician

Referring Physician Signature: _____

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