fraserhealth

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

HEART FUNCTION CLINIC REFERRAL
JIM PATTISON OUTPATIENT CARE & SURGERY CENTRE

CDXX104705A Apr 14/11 Page: 1 of 1

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:** ___/___/___ (DD, MM, YYYY) **Gender: M** ☐ **F** ☐

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 _____
  - O Before we can book the patient
  - O Prior to the pts appointment

Additional health care professional who needs to be CC'd

Name _____ Fax _____

Address _____

Printshop # 261995

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: _____