



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



Name:

PHN:

DOB:

MRN:

Heart Function Clinic Referral Form

Referral Date: _____

**Victoria Heart Function Clinic
Cardiology**

Phone: 250-519-1601

Fax: 250-370-8267

**Nanaimo Heart Function Clinic
Internal Medicine**

Phone: 250-740-6926

Fax: 250-740-6956

**Campbell River Heart Function Clinic
Internal Medicine**

Phone: 250-286-7153

Fax: 250-286-7103

Referring Provider	MSP #		Patient Name		
Phone #			Patient Address		
Fax #			City	Phone Number	
Family Practitioner			Province	Postal Code	
REASON FOR REFERRAL			CARE REQUESTED		
	Category	Target	Clinical Scenarios	(please select all that may apply)	
<input type="checkbox"/>	URGENT	2 weeks	<ul style="list-style-type: none"> Progressively worsening heart failure Post hospitalization heart failure Post MI heart failure New diagnosis of heart failure & unstable 	<input type="checkbox"/> Heart failure education <input type="checkbox"/> Diagnosis and Investigations <input type="checkbox"/> Treatment initiation and/or recommendations <input type="checkbox"/> Complex disease management <input type="checkbox"/> Take Heart exercise program	
<input type="checkbox"/>	Semi-urgent	4 weeks	<ul style="list-style-type: none"> New diagnosis of heart failure and stable Heart failure with symptoms, but not decompensated 		
<input type="checkbox"/>	Scheduled	6 weeks	<ul style="list-style-type: none"> Chronic heart failure 		
<input type="checkbox"/>	Scheduled	12 weeks	<ul style="list-style-type: none"> Asymptomatic heart failure 		
SOURCE OF REFERRAL					
				<input type="checkbox"/> Family Practitioner	<input type="checkbox"/> Specialist
				<input type="checkbox"/> Emergency	<input type="checkbox"/> NP
				<input type="checkbox"/> In-patient discharge	
EXTENT OF THE TRANSFER OF CARE					
(please select one option below)					
<input type="checkbox"/> Shared care until stable, then return care <input type="checkbox"/> Heart Function Clinic to manage until stable, then return care <input type="checkbox"/> Heart Function Clinic to advise only					
SPECIFIC QUESTION REFERRING PROVIDER WOULD LIKE ANSWERED					
Mandatory supporting documents:			Supporting documents, if available:		
<input type="checkbox"/> Current Medication list and allergies <input type="checkbox"/> Drug intolerances <input type="checkbox"/> Patient history including co-morbidities <input type="checkbox"/> Code Status <input type="checkbox"/> Full code <input type="checkbox"/> Do not resuscitate <input type="checkbox"/> Other consultant's letters relevant to the patient's assessment and management			<input type="checkbox"/> Previous cardiac investigations outside of VIHA (Echo, MUGA, MIBI, heart catheterization, device information) <input type="checkbox"/> Lab results not available in VIHA system (including electrolytes, creatinine, eGFR, TSH, cholesterol, fasting glucose, HbA1c, NT-pro BNP or BNP, liver function tests, uric acid)		

To expedite care, PLEASE ensure ALL aspects of this form are completed.