REFERRAL TO HEART FUNCTION CLINIC

Please complete and fax to:
Anna-Gail Dillomes at 416-340-4134 or email anna-gail.dillomes@uhn.ca

Referral Date: _____ Referring From: ☐ Hugh Allen Clinic ☐ Northern Clinic ☐ Sandy Lake Health Centre ☐ Other:	Referring Physician/NP: _____ CPSO#: _____ OHIP Billing #: _____ Tel: _____ Fax: _____

PATIENT INFORMATION:

Name: _____

OHIP Number: _____

Date of Birth: _____

Address: _____

Band Number: _____

Tel: _____ Email: _____

Caregiver or Alternative Contact: _____

Baseline characteristics	Current Treatment:	
EF: _____%	Loop diuretic	Yes / No
	Beta-blocker	Yes / No
NYHA class: 1 / 2 / 3 / 4	ACEI / ARB / ARNi	Yes / No
	MRA	Yes / No
Etiology: _____	Ivabradine	Yes / No
	SGLT inhibitor	Yes / No
	AICD / CRT	Yes / No
	Pacemaker	Yes / No

REASON FOR REFERRAL: (check all that apply)
☐ New diagnosis of heart failure ☐ Existing stable heart failure without recent follow-up, NYHA class I-II symptoms ☐ NYHA class III-IV symptoms of heart failure ☐ Persistent symptoms/signs of heart failure ☐ Recent admission or ER visit with heart failure ☐ Other:
Previous Cardiology visit: Has the patient previously been seen by a Cardiologist? ☐ Yes ☐ No If yes – date of last appointment: Name of cardiologist:
CONSULTATION REQUEST: Please expand on the reasons for referral and include the most recent clinical note, any relevant previous consultation notes, cardiac testing results, medications list and allergies.
IMPORTANT: Attach recent ECG, Holter, Echocardiogram, Stress test, last cholesterol, relevant troponin level, BNP, cardiac consult notes if available.

Signature of Referring Physician:

_____

Please complete and fax to:
Anna-Gail Dillomes at 416-340-4134 or email anna-gail.dillomes@uhn.ca