SOUTHLAKE
REGIONAL HEALTH CENTRE

Medical Arts Building
581 Davis Drive, 5th floor, Suite 513
Newmarket, ON L3Y 2P6
Telephone: 905-895-4521, ext. 2171

Health Record #: _____ Complete or place barcoded
Patient Name: *(Print first, last)* _____ patient label here
DOB: mm / dd / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: mm / dd / yy

Heart Function Program Referral

Fax: 905-952-2462

Patient Name: *(please print first, last name)*	**Patient Address:**
Phone Number:	

REASON FOR REFERRAL:

❑ Hospitalization where CHF is the primary diagnosis ❑ NYHA Class III – IV congestive heart failure ❑ End stage CHF: ❑ Advanced therapies ❑ Palliative	❑ Ontario telemedicine network (OTN) for virtual visits ❑ Other:

URGENCY OF APPOINTMENT:

❑ Less than 2 weeks* ❑ Less than 1 month ❑ Greater than 1 month	*Reserved for patients with high likelihood of ER visit or hospital admission within the next 2 weeks - **must** be accompanied by phone call to the Heart Function Clinic at 905-895-4521 ext. 2934 to coordinate the appointment.

HEART FUNCTION INFORMATION:

Does the patient have a cardiologist? ❑ No ❑ Yes Dr. _____

LVEF: ❑ less than 30% ❑ 30% – 39% ❑ 40% – 49% ❑ greater than or equal to 50% **NYHA Class:** ❑ I ❑ II ❑ III ❑ IV

Etiology of Heart Failure: ❑ Ischemic ❑ Non-Ischemic ❑ Valvular ❑ Diastolic dysfunction ❑ Other: _____

ENCLOSED DOCUMENTATION:

❑ Consultation note	❑ Discharge summary	❑ Echocardiogram	❑ Cardiac MRI
❑ Angiogram/PCI report	❑ Nuclear SPECT	❑ MUGA	❑ Other: _____

CLINICAL SUMMARY:

REFERRING PRACTITIONER INFORMATION:

Referring Name:	**Billing Number:**
Referring Signature:	**Date:** dd / mm / yy