

Please fax this completed form and supporting documents to 613 696-7159.

Referring Information

Referring physician: _____

Centre/ Office: _____

Address: _____

Phone: _____ Fax: _____

Date submitted: _____

Patient is referred for: (select one)

- General heart failure assessment/ optimization (*OHIP Patients only*)
- Evaluation of advanced heart failure therapies – VAD/ Transplant (*ON /QC/ NL/ NU residents only*)

Patient meets the following referral criteria: (select applicable)

- EF less than 35%
- Age \leq 75 years
- No co-morbidities resulting in limited lifespan of \leq 12 months

OR

- If the patient does NOT meet all 3 criteria, please explain your rationale for referral.

Inpatient transfers from regional hospitals → Do NOT use this form.

If your patient needs immediate urgent care (i.e. severe heart failure, cardiogenic shock), please call UOHI for consideration of patient transfer:

- Monday - Friday 08:00-1530: 613 696-7061
- Off Hours: 613 696-7000 (press 0)

You must make direct phone contact with the appropriate coordinator/ MD to complete urgent referral.

Patient Demographic Information

Patient name: _____ DOB (dd/mm/yyyy): _____

Address: _____ City: _____

Postal code: _____ Phone: _____

Health Card Number (include version code if applicable): _____

Biological Sex: _____ Height: _____ Weight: _____

Patient Clinical Information – Cardiac

Brief History of HF (include etiology if known): 	
NYHA Class:	NT-proBNP/ BNP (if available):
ABO (if known):	eGFR or Creatinine (most recent):
Left Ventricle Ejection Fraction:	Date of ECHO:
Current Treatments: <i>(Include comments and doses where applicable)</i>	
Loop Diuretic:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Anti-arrhythmic:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Beta Blocker:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
ACEI/ ARB/ ARNI:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
MRA:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Ivabradine:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
SGLT2 Inhibitor:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Hydralazine/Nitrates:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
ICD:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Pacemaker/ CRT:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

Additional Medical History

Medical history/ Co-morbidities:

Other relevant medications:

Supporting documents

If available, please include with the referral form:

- Consultation and discharge notes
- Recent lab results including CBC, electrolytes, creatinine, BNP/ NT-proBNP, liver enzymes
- Echocardiogram (send CD images if available)
- ECG
- CXR
- Any age specific cancer screening (e.g. FIT/colonoscopy, mammogram, PAP smear, PSA)
- Any advanced therapies work-up testing (e.g. LHC/ RHC, Dopplers, CTs)

Note

The UOHI Heart Function Clinic focuses on high-risk heart failure patients and patients who may be candidates for advanced heart failure therapies (VAD/ Transplant). If referral is accepted, we will contact the patient and book an appointment.

Contact info

Heart Function Clinic Fax: 613 696-7159

Heart Function Clinic Nurse Phone: 613 696-7000 ext. 16438