REFERRAL TO HEART FUNCTION CLINIC

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UHN Peter Munk Cardiac Centre
TED ROGERS CENTRE FOR HEART RESEARCH

Please include the LATEST CLINIC NOTES, TEST RESULTS AND A CD OF ANY CARDIAC TESTS.

REFERRAL FORMS WILL BE RETURNED IF MISSING ANY INFORMATION

Referral Date: _____
Referring Physician: _____

Address: _____
_____
_____

Tel: _____
Fax: _____

Patient's Name: _____

OHIP #: _____

ADDRESS: _____

PHONE: _____

DOB: _____ **Sex:**_____ **Weight:**_____ **(kg / lb)**

Baseline Characteristics:

EF _____ **(%)**

NYHA class 1 / 2 / 3 / 4

Etiology _____

Current Treatment:

Loop diuretic	**yes / no**
Beta-blocker	**yes / no**
ACEI / ARB /ARNi	**yes / no**
MRA	**yes / no**
Ivabradine	**yes / no**
SGLT inhibitor	**yes / no**
AICD	**yes / no**
CRT	**yes / no**

REASON FOR REFERRAL

☐ Evaluation for advanced therapies (Heart transplant/LVAD)
☐ Medication titration and optimization
☐ Post hospitalization or ED visit **(MUST include BNP if referred from ED)**
☐ Diagnostic evaluation

Sept 23, 2020

Please note: HFC at PMCC focuses on high risk patients who may be candidates for advanced heart failure therapies including transplant and mechanical circulatory support. Your patient may be triaged to an alternative cardiac clinic based on the information provided.

Office use only

Triage to: □ PMCC HFC □ GCC □MSH (qHF) □WCH □ Other _____

Visit Type: □ In-Person □ OTN □ Phone Visit

See within: □ < 2 weeks □ < 6 weeks □ < 12 weeks □ Other _____

Testing required: □ ECG □ Echo □ BNP □ Routine clinic labs □ Other _____