Feb 06

DIAGNOSTIC HEART FAILURE CLINIC REFERRAL FORM

DATE SENT ____ ***DATE RECEIVED*** ____ ***APPOINTMENT DATE*** ____

PATIENT DETAILS

Name: .....

SEX: Male / Female DOB: .....

NHS Number .....

Address: .....

.....

.....

Post Code: .....

TEL NO: (essential) .....

Hospital Number .....

GP DETAILS

GP Name: .....

Practice Name: .....

Practice Address:

stamp

Tel: .....

Fax: .....

ESSENTIAL investigation to be provided with referral

ECG (MUST be included with referral) ☐ BNP (if available) ☐

If the ECG is normal then Left Ventricular Systolic Dysfunction is unlikely.

DESIRABLE investigations that can be forwarded after referral. Please circle which have been performed.

U&Es, Creatinine, FBC, Glucose, Liver function tests, Thyroid function tests, lipids.

Symptom review

1.	Breathlessness	YES / NO
2.	Orthoponea	YES/ NO
3.	Reduced Exercise Tolerance	YES / NO
4.	Peripheral Oedema	YES / NO
5.	PND	YES / NO
6.	Fatigue/Lethargy	YES / NO
7.	Other please specify	

Past medical history

1.	Previous MI	YES / NO
2.	History of Angina	YES / NO
3.	Hypertension	YES / NO
4.	Valvular Disease	YES / NO
5.	Heart Murmur	YES / NO
6.	Arrhythmias	YES / NO
7.	Other please specify	

Clinical review

Physical examination

Current Medication (please attach printout if available)

Please fax this referral to the number given below.

0121 424 1074

Telephone for enquiries: 0121 424 0736

Please circle preferred site: HEARTLANDS SOLIHULL GOOD HOPE (fax to: 49018)

Office use only: Appropriate referral – yes / no
If inappropriate, state destination of referral