**Heart Failure Clinic Referral Form**

(Items with \*\* are required for processing)



Routine (within 1 month)  **URGENT** (within 1 week)

**Patient Information**

Interpreter Needed?Yes  No Preferred Language:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name, First Name\*\* |  | |  |  | | DOB\*\* | |
| Gender\*\*  Male  Female |  | |  |  | Phone\*\* | | |
| Address\*\* |  | |  |  | | | City\*\* |
| State\*\* |  | ZIP Code\*\* | |  | Secondary Contact: | | |

**Reason for Referral**

|  |  |
| --- | --- |
| Cardiac Diagnosis/ ICD 10 (list all) \*\* | |
| Date of last Echocardiogram\*\* | Ejection Fraction\*\* |
| Date of last NT-proBNP or BNP\*\* | Result\*\* |
| Previous Cardiac Testing & date (i.e. angiogram, catheterization) \*\* | |
| Physician Requested:  If physician requested is unavailable, can patient be seen by another provider?  Yes  No, contact referring provider | |
| Service Requested\*\*  Heart Failure Consult  Heart Failure 2nd Opinion  VAD/ Transplant Evaluation  Arrhythmia Management  Cardiothoracic Surgery  Cardiac Oncology  Amyloidosis  General Cardiology | |

**Referring Provider Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Referring Provider Name\*\* |  |  |  | PCP Name |
| Practice Name\*\* |  |  |  | |
| Office Address\*\* |  |  |  | City\*\* |
| State\*\* |  | ZIP Code\*\* |  | NPI Number |
| Phone\*\* | Fax\*\* |  | Provider Specialty | |

