**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  |

