

Heart Failure Clinic Referral Form

(Items with ** are required for processing)

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

Patient Information

Last Name, First Name**		DOB**
Gender** <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone**	
Address**		City**
State**	ZIP Code**	Secondary Contact:
Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No Preferred Language:		

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? <input type="checkbox"/> Yes <input type="checkbox"/> No, contact referring provider	
Service Requested**	
<input type="checkbox"/> Heart Failure Consult <input type="checkbox"/> Heart Failure 2 nd Opinion <input type="checkbox"/> VAD/ Transplant Evaluation <input type="checkbox"/> Arrhythmia Management <input type="checkbox"/> Cardiothoracic Surgery <input type="checkbox"/> Cardiac Oncology <input type="checkbox"/> Amyloidosis <input type="checkbox"/> General Cardiology	

Referring Provider Information

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



Physician Referral and Information
at Stanford Medicine

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