



WRHN

Waterloo Regional Health Network

Phone: 519-749-6919

Fax: 519-749-6785

Last Name

First Name

Health Card Number

Phone

Date of Birth (D/M/Y)

WRHN HEART FUNCTION CLINIC REFERRAL FORM

(*INCOMPLETE FORM WILL BE RETURNED***)****

Please send copies of the following information with every referral:

Admission/Discharge Note

2D echo completed within the past 6 months

Chest X-ray Report and ECG

Specialty Consult Notes

Referral Criteria - patients must meet the following criteria:

At least two hospital visits for heart failure within the last year (dates required): _____

NYHA Class III-IV CHF

Patients will be considered on an individual basis if they have had one admission for heart failure within the last year and meet one or more of the following criteria: (check all that apply)

Advanced heart failure (i.e. recurrent ER visits and/or frequent hospital admissions for heart failure)

Sub-optimal drug therapy

REASON for REFERRAL:

CURRENT MEDICATIONS

EF: <20% 20-39% 40-59% >60%

NYHA class 1 / 2 / 3 / 4

REFERRAL DATE (D/M/Y): _____

REFERRING PHYSICIAN INFORMATION:

NAME (PRINT): _____

ADDRESS: _____

TEL: _____

FAX: _____

SIGNATURE: _____

FAMILY PHYSICIAN

NAME: _____

ADDRESS: _____

TEL: _____

FAX: _____

HFC USE ONLY

Reviewed: MD _____ Date _____

Accepted: Follow-Up Timing _____

Declined: Referral to HFMU Clinic _____

Cardiologist _____ Other _____

COMMUNITY CARDIOLOGIST

NAME: _____

ADDRESS: _____

TEL: _____

FAX: _____