

Community Heart Failure Service - Referral Form

***Please do not refer if your patient if already under regular review by cardiology team  in secondary care. Please contact us if you would like to discuss this further.***

***NB: We undertake Echo in clinic - Do not duplicate Echo request elsewhere.***

 Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient****Surname** |  | **First Names:** |  |
| **Address &****Postcode:** |  | **Date of Birth:** |  |
| **NHS No:** |  |
| **Male / Female (Please circle)** | **Tel No(s):** |  |

 Please direct telephone enquiriesto: 0117 9617153

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|  **Reason for Referral**  |
| **□ New suspected Heart Failure** | **□ Clinically unstable heart failure for treatment**  **review and stabilisation** |
| **Additional information – *please also include any accessible information needs.*** |
| **Previous Intolerance/contraindication to: ACE □ B Blocker □** **Other/Allergies (Please state):** |

|  |  |
| --- | --- |
| **REFERRER NAME:** | **TEL NO:** **FAX NO** |
| **PRACTICE ADDRESS:** | **PRACTICE CODE:** |

***In order that your patient can be accepted into the service and seen as soon as possible please supply the following essential information with this referral:***

1. NT-proBNP result (Mandatory for all patients) : pg/mL □
2. A summary print out of past Medical History and Current Medications (Mandatory) □
3. A recent ECG - if available □
4. Chest X Ray - if available □

 *Please email referral to:***sirona.heartfailureservice@nhs.net**