



Patient ID

**Referral Form
Heart Failure Clinic**

Referring physician:

To: Dr. _____

Reason for referral:

or

First available: _____

LVEF:

Method and Date:

NYHA Class: I II III IV

Medications:

- Angiotensin Converting Enzyme Inhibitors
- Angiotensin Receptor Blockers
- Beta-Blockers
- Mineralocorticoid Receptor Antagonist or Aldosterone Receptor Antagonist
- Digoxin
- Furosemide
- Metolazone
- Others

Clinic Notes/Discharge summary attached:

Yes No See Sorian

Urgency: Stat within 4 weeks other (specify)

Do you want the heart failure clinic physicians to contact you?

Yes No

**Fax number: 416-864-5566
E-mail: HeartFailureClinic@smh.ca
Attention: Heart Failure Clinic**