Heart Failure Specialist Nursing Service

Referral Form *(post migration to INTS s1 unit version July 22)*

Date of referral:…………………………………………..

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| PATIENT DETAILS Name: D.O.B:NHS Number:  | Address:Post Code: Tel. No:  |
| REFERRED BY Name: Tel. No: Please tick below:-Cardiologist Consultant GP Specialist Nurse Ward / Cardiology Practice NurseSelf-referral Other please state:  |

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| **EXCLUSION CRITERIA Referrals received for patients with the following will be declined:-** * **If patient has no echocardiogram or the echocardiogram is older than one year old.**
* **Stable patients already on optimised treatment.**
* **Patient discharged from the Heart Failure Service within last 12 months with no symptom / medication changes within this time.**
* **Post MI patients that have NOT had a three month repeat echocardiogram.**
* **Stable patients with mild LVSD will not be accepted in the service, these patients will be expected to be managed by primary care.**
* **Patients on renal dialysis will NOT be accepted into the service.**

**Patients diagnosed with right ventricular systolic dysfunction / preserved ejection fraction (HFpEF) or diastolic heart failure (*The* *service only accepts patients with left ventricular systolic dysfunction - those still undergoing investigations to confirm diagnosis WILL BE rejected only those with a confirmed diagnosis should be referred).***  |

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| **INCLUSION CRITERIA (*Please ensure all relevant information is ticked, failure to do so may result in a delay in the referral being processed)*** **Echocardiogram within the past 12 months: Yes****Echo Findings *(please tick):* Moderate Severe*****A copy of the echocardiogram MUST be forwarded with this referral failure to supply this will result in a delay in the referral being processed.*** |

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| **REASON FOR REFERRAL *(Please tick the primary reason for referral):*** **Complex Patient Management Titration of Medication Patient Education** **Additional information:**  |

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| **PAST MEDICAL HISTORY / DISABILITIES** |

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| **MEDICATION** |