Interior Health
Every person matters

EK Heart Function Program

REFERRAL FORM

FAX: 1-250-489-6420 PHONE: 1-250-489-6414

Cranbrook
Kimberley
Creston
Elk Valley
Columbia Valley

PLEASE SEND REFERRALS for the following DIRECTLY to INTERNAL MEDICINE Office
Asymptomatic A-Fib, Chest Pain ONLY, Stress Tests (FAX 250-417-2973)

Client Demographics

***Referral URGENCY ☐ <1 month ☐ >1month

Name: _____ Home Phone: _____

PHN: _____ DOB: _____ Cell Phone: _____

Address: _____ Email: _____

City: _____ Postal Code: _____ ***MOST (required): _____***

Heart Failure (HF) Diagnosis

☐ UNSTABLE NEW/ Acute Heart Failure
(Post MI HF; worsening HF; HF requiring hospitalization)

☐ STABLE NEW/ Acute Heart Failure

☐ Chronic Systolic HF

☐ Chronic Diastolic HF

NYHA Class: I ☐ No Symptoms; II ☐ Symptoms with ordinary activity; III ☐ Symptoms with < ordinary activity; IV ☐ Symptoms at rest

☐ Recent Echo (within 6 months) Date: _____ LVEF: _____

Reason for Referral: Select ALL that apply

☐ Cardiac Education/ Self-Management

☐ RN-supervised Walking Program (Cranbrook only)

☐ Heart Function Clinic with Internist-directed Multi-disciplinary Care

Eligibility Criteria - MUST HAVE CURRENT DYSPNEA WITH ONE OF THE FOLLOWING:

- Elevated JVP; Pulmonary Creps; Peripheral edema; Increased Waist Circumference: **WITH DYSPNEA**
- Radiological congestion/effusions; BNP >400mg/mL; LVEF <45%; Diastolic dysfunction: **WITH DYSPNEA**
- Atrial Fibrillation: **WITH DYSPNEA**

☐ Tele-home Monitoring with RN-managed Care

Eligibility Criteria – same as for Heart Function Clinic PLUS ALL OF:

- Be able to stand on scale
- Be cognitively able to use monitors and follow direction in English (or with daily caregiver assistance)
- NO Home safety concerns for nurse

NOTE: Reduced benefit of Tele-home Monitoring if patient on Hemodialysis

Attach referral letter and/or indicate below brief Heart Failure history, and any specific question you would like answered:

Please attach any pertinent information not available in Meditech.

Medication Action Plan: I agree that above mentioned Patient make take an additional

Furosemide _____ mg PO PRN for up to 3 days at a time for increased S &S of HF (40 Tabs).

Physician: _____ Billing #: _____

FAX ALL Referrals for EK Heart Function Program to: 1-250-489-6420

Referring Physician: _____ Date: _____

Printed Name: _____ Office Phone: _____ Fax: _____