**Referral to the Cardiology Clinic**

 **HEART FAILURE**



**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  |
| Surname |  | Forenames |  |
| Previous surname |  | Title |  | Sex |  |
| Date of birth |  | Home tel. no. |  |
| Address |  | Mobile no. |  |
| Work tel. no. |  |

**Referrer Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Clinician |  | GP Practice / Department |  |
| Date of Referral |  |
| Base |  | Practice Code/ID |  |
| Address |  | Telephone |  |
| **NTproBNP** |  | See attachment regarding NTproBNP – Suspected new HF referrals must have NTproBNP as per the NICE HF Pathway |
| **Previous diagnosis of HF?** | Yes  | [ ]  | No | [ ]  | If known HF, does not need NTproBNP, and will be triaged as per clinical urgency |
|  |

**Communication and Accessibility needs:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Interpreter required?: | Yes | [ ]  | No | [ ]  | Wheelchair access required?  | Yes | [ ]  | No | [ ]  |
| Language:  |  | Learning Disability:  |  |
| Hearing: |  | Other disability needing consideration:  |  |
| Vision: |  |

**History of presenting complaint:**

|  |
| --- |
|  |

**Current medication (please list):**

|  |  |
| --- | --- |
|  |  |
|  |  |
| Allergies:  |

**Investigations:**

**Please ensure the following investigations have been done within the past month and tick to confirm:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| UECreat  | [ ]  | Random glucose  | [ ]  | FBC  | [ ]  |
| Random cholesterol  | [ ]  | LFT  | [ ]  | TFT  | [ ]  |
| NTproBNP  | [ ]  |  |  |  |  |

**Blood Results** (Last 12m):

|  |  |  |
| --- | --- | --- |
| **FBC** |  |  |
| **UE** |  |  |
| **LFT** |  |  |
| **CRP** |  |  | **ESR** |  |
| **TFTs** |  |  | **INR** |  |
| **Bone** |  |  |
| **Iron** |  |  |
| **Vitamins** |  |  |
| **Lipids** |  |  |
| **Random Glucose** |  | **Fasting Chol.** |  |
| **Fasting Glucose** |  | **HbA1c** |  |
| **BNP** | None found | **NT-proBNP** |  |

**Medical Problems:**

|  |
| --- |
|  |

**Please send via eRS**

Sent electronically, no signature required

