Heart Failure Referral Form

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Patient Label	**Ward** **Date Admitted**
History of presenting complaint	**Limitations** (tick all that apply) ☐ SOB ☐ Orthopnea ☐ Cough ☐ Chest Pain ☐ Palpitation ☐ Fatigue ☐ Leg edema ☐ Mobility problems ☐ Dizziness
NYHA Classification I II III IV	
Previous Medical History	
Medications	**Allergies**

Baseline Observations				**Blood Chemistry**		
Heart Rate	Heart Rhythm	Resp Rate	Oxygen Sats	Na^+	Creat	Hb
				K^+	Urea	Alb
BP		Weight		**Date Taken**		

Investigations	**Date**	**Abnormalities Noted** (if none, please state)
ECG		
CXR		
ECHO		

Signature	**Name (please print)**	**Date**

Please Fax Referral to: 416-469-6538