MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Heart Function Referral Form

Reason for Referral

Previous Medical History

Patient Information

Name

DOB

MRN

HC #

Patient Label

HF Risk Assessment (check all that apply)

- ☐ ≥2 admissions for heart failure in last 12 months
- ☐ 2 visits to the ER for HF in last 12 months
- ☐ Kidney disease or BP limitations to titration of medications
- ☐ Patients being discharged with a new diagnosis of heart failure for rapid reassessment
- ☐ HF post-myocardial infarction

Other Medications

Medications

Furosemide	__ mg (daily / bid / tid)	
ACEi	Y / N	No
ARB	Y / N	No
Beta-blocker	Y / N	No
MRA	Y / N	No
ARNI	Y / N	No
SGLT2 inhibitor	Y / N	No

Allergies

Baseline Characteristics		Blood Chemistry		
LVEF (%) – pls repeat echo if >6 mos	NYHA I ☐ II ☐ III ☐ IV ☐	Na	Hb	TSH
		K	A1c	Ferritin
HF Etiology	Weight	Cr	NTproBNP	
		Date Taken		

Signature	Name	Date

Please fax completed referral and supporting documents to 416-469-6538