HEART FAILURE DIAGNOSTIC PATHWAY REFERRAL FORM
USE SCI GATEWAY FORM unless the gateway unavailable

Patient Details

Name……………………………………………………… GP Name…………………………………………

Address……………………………………………………… Practice Code…………………………………

……………………………………………………………… Tel No……………………… Fax…………………

Tel No……………………………DoB…………………… CHI Number……………………………………

Interpreter required? Y ☐ N ☐ If Y spoken language ……………………………

Preferred hospital (please circle) GRI WIG IRH RAH VoL Victoria Stobhill Southern Gen

Preferred hospital will be offered for appointment unless (unusually) waiting times guarantee cannot be met

INDICATION FOR REFERRAL

Please note – patient must have a clinical suspicion of heart failure + at least one symptom to be eligible for this service. Patient must also have a recent Hb and creatinine result reported.

Tick all that apply

Clinical suspicion of heart failure	☐	**Orthopnoea**	☐
Dyspnoea on exertion	☐	**Ankle oedema**	☐
Dyspnoea at rest	☐	**Paroxysmal nocturnal dyspnoea (urgent medical cardiology referral if current)**	☐

Haemoglobin	**Date of test………………………… (must be within 1/12 of Referral)**	**Creatinine**	**Date of test………………………… (must be within 1/12 of Referral)**
	Result……………………………		**Result……………………………**

Relevant Past Medical History

Previously seen by Cardiologist? Y ☐ N ☐ Dr……………………………………
Hospital…………………………………………………… Date……………

Previous echo Y ☐ N ☐ Hospital……………………………………………………
Result…………………………………………………… Date……………

Myocardial infarction	☐	Angioplasty (PTCA)	☐	Hypertension	☐
Unstable angina	☐	Valvular heart disease	☐	COPD	☐
Angina	☐	Valve surgery	☐	Asthma	☐
CABG	☐	Atrial Fibrillation	☐		

RELEVANT DRUG HISTORY (please append repeat prescribing list + any acute prescriptions)

Thiazide diuretic (name)	☐	B-blocker	☐	Calcium channel blocker (verapamil/diltiazem)	☐
Loop diuretic (name)	☐	ACE inhibitor	☐	Calcium channel blocker (other)	☐
Combination diuretic (name)	☐	Angiotensin receptor blocker	☐	Antiarrhythmics (including amiodarone)	☐

Spironolactone/eplerenone ☐

PLEASE ASK PATIENT TO BRING ALL MEDICATIONS ALONG TO CLINIC

- All information should be completed to ensure a safe and efficient service is provided to your patient.
- **Please Fax form to 0141 232 1020** An appointment will be sent to your patient
- Telephone number for Central booking service 0141 232 0793

Referring Doctor's signature……………………………… Please print name……………………………………
Date…………………………………………………

Created Jan 2011