SOUTHLAKE
REGIONAL HEALTH CENTRE

Medical Arts Building
581 Davis Drive, 5th floor, Suite 513
Newmarket, ON L3Y 2P6
Telephone: 905-895-4521, ext. 2171

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Heart Function Program Referral

FAX: 905-952-2462

Patient Name: *(print first, last)*	**Patient Phone Number:**

Referral Criteria: Patients must meet one of the following:

❑ Recent hospitalization where heart failure is the primary diagnosis.

❑ NYHA Class III-IV CHF

Does this patient have a cardiologist?

❑ Yes: Dr. _____

❑ No

Ejection Fraction

❑ Less than 35%

❑ Greater than 35%

Urgency of Appointment

❑ Within 1 week: Discharge date: _____

❑ Less than 1 month

❑ Greater than 1 month

Completeness of the referral will expedite care in the Heart Function Program
Please send copies of relevant information including:

- **CONSULTATION NOTE**
- **CARDIAC DIAGNOSTICS**

Same day diagnostic test requested at first visit.

❑ Echo ❑ Stress Test ❑ Holter

Referring Physician/NP: *(print first, last)*

Physician/NP Signature:	**Date:** dd / mm / yy