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| **Stockport Heart Failure Service REFERRAL FORM** |  |
| **Please read this information before completing this form.**  **The referral will be triaged by the clinical team. Please ensure the referral form is completed in full, if incomplete the referral could be rejected.**  If considering a heart failure diagnosis and no recent echocardiogram please check NT pro BNP ***prior to referral***:   * if < 400 - heart failure unlikely in an untreated patient. Consider differential diagnosis   and treat manageable conditions   * if 400-2000 - refer for direct access echo and refer on to the service if the echocardiogram shows impaired left ventricular function * if >2000 - refer urgently to heart failure service who will arrange the echocardiogram and subsequent follow up if the echocardiogram shows impaired left ventricular function | |

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| **Patient Information** |

Title: Choose an item. NHS Number: Click or tap here to enter text.

Surname: Click or tap here to enter text. First Name(s): Click or tap here to enter text.

Preferred Name: Click or tap here to enter text. Date Of Birth: Click or tap here to enter text.

Gender: Choose an item. Ethnic Origin: Choose an item.

Address: Click or tap here to enter text.

Postcode: Click or tap here to enter text.

Home Phone: Click or tap here to enter text. Mobile/Work: Click or tap here to enter text.

Preferred named contact: Click or tap here to enter text. Relationship: Click or tap here to enter text.

Preferred contact number: Click or tap here to enter text.

Doctor's Name: Click or tap here to enter text.Practice Phone No: Click or tap here to enter text.

Practice Email: Click or tap here to enter text.

Practice Address: Click or tap here to enter text.

Consents to the referral and attending for an echocardiogram if on the 2 week pathway Choose an item.

(if does not consent the referral cannot be processed)

Consents to data sharing (medical record/ clinical information) Choose an item.

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| Is there any relevant information known about the patient which the service needs to be advised about /or home environment? (eg safety factors, housebound, NOK, carer details if required, LPOA)  Click or tap here to enter text.  Permission to speak with NOK/ relative/ carer: Choose an item.  NOK/ relative/ carer details: Click or tap here to enter text.  Patient able to attend GP surgery/ hospital appointments? Choose an item.  Translator Required: Choose an item. Language required: Click or tap here to enter text.  Special requirements: eg sign language Click or tap here to enter text. | | | | | | |
| **Referral Pathways – Please indicate which pathway you are referring on** | | | | | | |
| 1. Routine Referral – recent echocardiogram demonstrating left ventricular impairment (must be attached with the referral) ie Ejection fraction under 55% 2. Urgent Referral – NT pro BNP > 2000. The heart failure service will arrange an urgent echocardiogram and clinical review within 2 weeks, unless echo shows normal LV function | | | | | | |
| Reason for Referral – please complete with any recent clinical management/ medication changes/ recent related hospital admission:  Click or tap here to enter text.  Clinically Urgent? (Please explain why for triage purposes)  Click or tap here to enter text. | | | | | | |
| **Medical History** | | | | | | |
| Click or tap here to enter text. | | | |  | | |
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| **Medication** | | | | | | |
| Click or tap here to enter text. | | | | | | |
| **Allergies** | Choose an item. | | Details:Click or tap here to enter text. | | | |
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| Referrers Name | | Click or tap here to enter text. | | | Referrers Designation | Click or tap here to enter text. |
| Date | | Click or tap here to enter text. | | | Telephone number: Click or tap here to enter text.  Email: | |
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| **Stockport Heart Failure Service, 2nd Floor, Kingsgate House, Wellington Rd North, Stockport, SK4 1LW.**  **Tel: 0161 204 4670 Email:** [heartfailurestockport@stockport.nhs.uk](mailto:heartfailurestockport@stockport.nhs.uk) | | | | | | |