# Community Heart Failure Nurse Specialist Service
# Patient Referral Form

| **Name:**<br>Address:<br>Postcode:<br>Contact number: | (affix patient label if available) | CHI No: | DoB/Age: |
|---|---|---|---|
| | | GP: | Hospital No: if applicable |
| | | Ethnicity | Primary language: |
| Sex: Male / female | | Consultant Cardiologist | |

| **Inclusion criteria** | |
|---|---|
| Newly diagnosed LVSD | |
| Stable HF NYHA I/II | |
| No significant cognitive impairment | |
| Able to attend group education programme | |
| Lives within Greater Glasgow and Clyde catchment area | |

| **Aetiology** | | **ECHO** | |
|---|---|---|---|
| Ischaemic heart disease | | **LVSD** | None |
| Hypertension | | | Mild |
| Cardiomyopathy | | | Moderate |
| Other | | | Severe |

| **Planned cardiology follow up/Investigations** | | |
|---|---|---|
| Further clinic appointment | | |
| Coronary angiogram | | |
| Device | | |
| Other | | |

| Signature: | Designation: | | |
|---|---|---|---|
| Name: please print | Contact Number: | Date: | |

**Please fax or email this form to the service secretary, Susan Carr:**
**Fax Number: 0141 355 1750** [Susan.carr2@ggc.scot.nhs.uk](mailto:Susan.carr2@ggc.scot.nhs.uk)

| Tick each action as completed | ☑ | For office purposes only |
|---|---|---|
| Patient suitable for programme | | Comments: |
| GP letter sent | | |
| Invitation to patient sent | | |
| Enrol to education programme | | |
| Refer to HFLNS | | |
| Refer to GP | | |
| Refer to Practice Nurse | | |