Luton Community Heart Failure Nurse Specialist Referral Form

PLEASE EMAIL THIS REFERRAL FORM TO: CCS-TR.HEARTFAILURE@NHS.NET

If you wish to discuss prior to referral, please ring 0333 405 3126.

Newly suspected heart failure patients should be referred to the L & D rapid access Heart Failure Clinic for confirmation of diagnosis and management plan.

<table>
<tr><td>Patients Name:

Patients Address:

Date of Birth:</td><td rowspan="4">All patients referred to the Luton Community Heart Failure Service by a GP/Community Matron MUST have a diagnosis of LVSD confirmed by ECHO.

Echo findings (Please enclose report).</td></tr>
<tr><td>NHS Number:

Telephone No:

Next of Kin:

Housebound? Y ☐ N ☐</td></tr>
<tr><td>Ethnicity:</td></tr>
<tr><td>Interpreter Needed? Y ☐ N ☐

Language Spoken:</td></tr>
<tr><td>Is Patient Aware of referral?</td><td>All patients diagnosed with diastolic or heart failure with preserved ejection fraction (HFPEF) MUST be referred initially to a cardiology consultant.

For all referrals please include a print out of patient summary, including medication, medical history, and allergies (please tick box if included).

☐</td></tr>
<tr><td>Name of Referrer:

Contact Number:

GP Name:

GP Address:

Telephone No:

GP understands Specialist Nurse may alter medication or order blood tests</td><td>Etiology of Heart Failure:

Reason for Referral:</td></tr>
<tr><td>Signature of Referrer</td><td>Date of Referral</td></tr>
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