*Patient name*

*DOB*

*Health Card Number*

*Unit number*

# Cardiovascular Health Clinic

## REFERRAL FORM

**Phone:** 902-543-4604 (2222)    **Fax:** 902-543-8895

| Indication for Referral: | Relevant Clinical Information: |
|---|---|
| Stable Angina Pectoris: ___ | Arrhythmia: Describe: ___ |
| ACS: __ STEMI __ NSTEMI __ Unstable Angina | LVEF < 40%?: ___. Method: ___ |
| Stroke (CVA): __ hemorrhagic __ ischemic | Post-op PAD surgery. Date (YYYY-MM-DD): ___ |
| PAD: Details ___ | Post-op heart valve surgery: Date (YYYY-MM-DD): ___ |
| Chronic Heart Failure: etiology: ___ | Post-op CABG: Date (YYYY-MM-DD): ___ |
| TIA (Use **TIA Clinic Referral SS_TIARE [ER-0200]**) | Cardiac Arrest. Date (YYYY-MM-DD): ___ |
| Other: Details ___ | Cardiac Catheterization? Date (YYYY-MM-DD): ___ |
| | PCI (stent or angioplasty) Date (YYYY-MM-DD): ___ |
| | Stress test? Date (YYYY-MM-DD): ___ |
| | Diabetes Mellitus? Type ___ |
| | |

Referring Clinician: ___ Referral Date (YYYY-MM-DD): ___

## Heart Function Clinic (HFC):

**I suspect that my patient may have a new diagnosis of Congestive Heart Failure**

Patients with suspected Congestive Heart Failure will be seen by Cardiology/Internal Medicine on a priority basis, and appropriate patients will have ongoing follow-up care in the HFC

***See Reverse for Description of Services***

**Cardiovascular Health Clinic:**

The Cardiovascular Health Clinic works collaboratively with Primary Health Care to enhance chronic disease management in order to prevent unnecessary hospitalizations and ER visits. A referral includes an assessment and counseling by a Nurse Practitioner or Registered Nurse in the Cardiovascular Health Clinic within 1 month of receipt of referral, or sooner as indicated by triage. Features of the CV clinic include:

**1) Cardiovascular Risk Assessment and Comprehensive Risk Reduction Education**

- Assessment of patient specific cardiovascular risk factors
- Patient centered risk reduction education and goal setting with emphasis on self-management
- Individual consultation and education with a clinical Dietitian and other allied health professionals as needed
- Collaborative care with Primary Care Provider, as well as Chronic Disease Nurse Practitioner/Internal Medicine Specialists where appropriate

**2) Facilitation of Exercise**

- Tailored patient-centered exercise including risk stratification and exercise prescription adhering to the Canadian Association of Cardiopulmonary Rehabilitation (CACPR) Guidelines
- Includes any of the following:
    - Home and community based exercise
    - Medically supervised exercise in the formal **Cardiovascular Rehabilitation Program** (at the YMCA)

**3) Comprehensive Heart Failure Care**

CHF patients will receive ongoing assessment by a Nurse Practitioner (NP) specialized in CHF care in addition to the above care.

- Cardiology or Internal Medicine consultation and follow-up
- Optimization of pharmacotherapy as needed
    - Titrating heart-failure drug dosages

- Initiating evidence-based medications
- Diuresis of volume overloaded patients as needed