

Heart Failure Clinic

Fax 504.903.1605

Referral from: BMC EKL LJC LAK
 LIH UMC WOM Other: _____

Patient Label/Stamp

Attending Provider: _____ ID Number: _____

If Label/Stamp is Not Available Complete the Following:

Patient's Name: _____ Date of Referral: ___/___/___

Date of Birth: ___/___/___ Medical Record Number: _____

1° Contact Number: _____ 2° Contact Number: _____

Email: _____

Please Indicate Reason for Referral:

- 425.5 Cardiomyopathy: Alcoholic
- 425.1 Cardiomyopathy: Hypertrophic Obstructive
- 425.7 Cardiomyopathy: Nutritional and metabolic
- 674.5 Cardiomyopathy: Peri/Postpartum
- 416.00 Chronic Pulmonary Heart Disease (Right Heart Failure)
- 428.0 Heart failure: NOS
- 428.2 Heart failure: Systolic
- 428.3 Heart failure: Diastolic
- 398.91 Heart failure: Rheumatic (congestive)
- 429.83 Takotsubo Syndrome

Obtain EKG, ECHO, CBC, CMP, TSH, discharge BNP for all Heart Failure referrals if not already done.

Have the patient bring copies of any lab work, EKG, ECHO, and medical records not available at LIH.

Clinical History Relevant to this Referral: _____

Referring Provider's Signature: _____ ID Number: _____

Contact Number: _____ Referring Service/Clinic: _____

Fax Number: _____ Email: _____

OFFICE USE ONLY: Appointment Date: ___/___/___ Time: __:__ am/pm.

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

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