## Virtual Heart Failure Service Referral



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## PLEASE NOTE THAT \* INDICATES A MANDATORY FIELD **PROGRAM ADMISSION CRITERIA INCLUSION CRITERIA EXCLUSION CRITERIA** Met\* None\* · Diagnosis of heart failure · Advanced renal disease, dialysis (and be likely to respond and actively participate in service) · Advanced heart failure (not likely to respond and unable to actively participate in service) · Informed patient consent Must meet Private Health Fund Eligibility Cognitive impairment, without required carer support Technology restraints, no access to internet at home Patient is bed bound **PATIENT DETAILS** Name\* Address\* Estimated discharge date Private Health Insurer\* PHI Number\* Suffix D.O.B\* Does the patient identify as Aboriginal and/or Torres Strait Islander? Contact Number\* **NEXT OF KIN DETAILS GP DETAILS** Name Name Relationship Practice Contact Number Contact Number **REFERRER DETAILS** TREATING SPECIALIST DETAILS Hospital/Clinic Same as referrer details - skip below Referrer name\* Name Referrer role\* Phone Referrer signature\* Email or Fax Escalations will be managed by the patient's GP unless clinical need Referrer phone\* or treating specialist preference dictates otherwise If specialist has requested they would prefer to take governance for all Referrer email\* heart failure escalations for this patient please tick this box PATIENT MEDICAL DETAILS Diagnosis: **HFrEF HFpEF HFmEF** Recent ejection fraction: Past medical history Any recent medical issues or complications? No Yes - details Infections No Yes - details Known allergies Yes - details Nο Referred to cardiac rehab Not Suitable No Yes Unknown **MEDICATION TITRATION** Medication titration requested? Yes and Dr No will take governance over medication titration. Please complete Ramsay Home Health medication titration form

AR0053309 RHH VHFS referral to RHH 1pp A4