Northumbria Healthcare NHS
NHS Foundation Trust

North Tyneside Community Heart Failure Nursing Service Referral Form

TEL: 0191 238 0066 FAX: 0191 238 0068

Name				NHS number			
Address				Hospital number			
				Hospital		Ward	
Postcode		D.O.B		Age		Consultant	
Ethnicity		Tel no		Mobile			
GP name				Admission date		Discharge date	
& address				Occupation			
GP tel. no							

Social/Family History	**Significant Past Medical History**		**Written information given:**	
	IHD	☐	BHF Heart Failure Book	☐
	CABG	☐	Other (specify)	☐
	Valve Replacement	☐		
	Diabetes	☐		
	Hypertension	☐		
	Other	☐		

Diagnosis	✓	**Date**	**Drugs on discharge**	✓	**Drug name & dose**
CHF			Diuretic		
Type of MI			ACE Inhibitor		
AF			ARBs		
ICD			Betablockers		
BVP			Spironolactone		
Angina			Epelronone		
Chronic renal failure			Digoxin		
Ventricular arrhythmias			Warfarin		
Cardiomyopathy			Aspirin		
COPD			Clopidogrel		
ECHO			Statin		
			GTN		
Height _____			Weight _____		BMI _____

Alcohol	Yes / No	BP / Pulse		Smoker	Yes / No / Ex / Don't know
Hypercholesterolaemia	Yes / No	Cholesterol			

Physical Activity (Distance in Metres) =

Any Aids Used =

Comments

Management Plan: (medication titration, palliative etc)

PLEASE ATTACH ECHO REPORT & LAST BLOOD RESULTS

Referrals

Social Services	☐
Psychologist	☐
Smoking Cessation	☐
Dietician	☐
District Nurse	☐
Physio	☐
OT	☐

	Print Name	Signature	Form faxed by
Person Completing Form			