Stanford MEDICINE | Health Care

Clinic Phone: 650-724-4942 | Fax: 650-320-9443

Heart Failure Clinic Referral Form

(Items with ** are required for processing)

☐ Routine (within 1 month) ☐ **URGENT** (within 1 week)

Patient Information

Last Name, First Name**		DOB**
Gender** ☐ Male ☐ Female		Phone**
Address**		City**
State**	ZIP Code**	Secondary Contact:
Interpreter Needed?☐Yes ☐ No Preferred Language:		

Reason for Referral

Cardiac Diagnosis/ ICD 10 (list all) **	
Date of last Echocardiogram**	Ejection Fraction**
Date of last NT-proBNP or BNP**	Result**
Previous Cardiac Testing & date (i.e. angiogram, catheterization) **	
Physician Requested: If physician requested is unavailable, can patient be seen by another provider? ☐ Yes ☐ No, contact referring provider	
Service Requested** ☐Heart Failure Consult ☐ Heart Failure 2nd Opinion ☐ VAD/ Transplant Evaluation ☐ Arrhythmia Management ☐ Cardiothoracic Surgery ☐ Cardiac Oncology ☐ Amyloidosis ☐ General Cardiology	

Referring Provider Information

Referring Provider Name**		PCP Name
Practice Name**		
Office Address**		City**
State**	ZIP Code**	NPI Number
Phone**	Fax**	Provider Specialty

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