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| PATIENT DETAILSSUFFOLK COMMUNITY HEART FAILURE – GP REFERRAL FORM | | | | | |
| **Name:** |  | | | **Dob:** |  |
| **Address:** |  | | | **GP**  **Details:** |  |
| **Postcode:** |  | | | **NHS**  **Number:** |  |
| **Home Tel:** |  | | | **Work or Mobile No:** |  |
| **Presenting Symptoms:** | | | | | |
| **Previous Medical Histor*y*:** | | | | | |
| **Does the patient have a frailty score known? Y 🞎 N 🞎**  If yes please specify (mild, moderate, severe or Rockwood score 1-9): | | | | | |
| **ECHO Report :**  **BNP result :**  **See referral pathway - Map of medicine**  **(Please attach echo and BNP result ) and current medication sheet**  **For urgent admission avoidance referrals, please telephone & speak with specialist nurse** | | | | | |
| **Name of Referrer :** | | **Date:** | **Designation:** | | |
|  | |  |  | | |

## Tel: 0300 123 2425

**Email: suffolkcommunityhealthcare.referrals@nhs.net**

**Once this referral form has been completed please email.**