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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.**