NHS

SUFFOLK COMMUNITY HEART FAILURE – GP REFERRAL FORM

PATIENT DETAILS			
Name:		**Dob:**	
Address:		**GP Details:**	
Postcode:		**NHS Number:**	
Home Tel:		**Work or Mobile No:**	

Presenting Symptoms:

Previous Medical History:

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: suffolk.ccc@esneft.nhs.uk
Once this referral form has been completed please email.