Kawartha Lakes Haliburton
Ontario Health Team

KLH-OHT Heart Failure Chronic Disease Management Program (HF-CDMP) **Please Complete ALL information and include all related reports with this referral**	**Submit Referral To:** Phone: 705 738 7298 Fax: 833-685-0701 Email: CDMP@knfht.ca
Who to refer: newly diagnosed and stable, recent ED visit or hospitalization in the last 6 months, Chronic HF for ongoing support	

PATIENT INFORMATION:				
Last Name:	First Name:		Preferred Name:	
Address:		Apt:	City:	
Postal Code:	Primary Phone:		Secondary Phone:	
Date of Birth (yyyy-mm-dd):			Age:	Gender:
Health Card #:				
Caregiver/Contact (if applicable):				

REFERRAL INFORMATION:	**CLINICAL INFORMATION:**
Reason for Referral (check all that apply): ☐ Newly diagnosed Heart Failure ☐ Recent ED visit/Hospitalization ☐ Symptom monitoring and self-management support ☐ Patient/Caregiver education ☐ Medication review/support ☐ Community support referrals ☐ Tele-homecare/Remote monitoring assessment ☐ Community paramedicine support ☐ Other:	Recent Hospitalization (last 6 months): ☐ No ☐ Yes Key Co-Morbidities: ☐ HTN ☐ Diabetes ☐ COPD ☐CKD ☐ AFib ☐ Anemia ☐ Frailty ☐ Heart Valve Disease ☐ Coronary Artery Disease ☐ Obesity ☐ Sleep Apnea ☐ Substance Use ☐ Other: Attachments Included: ☐ Medication list ☐ Recent labs ☐ Discharge summary ☐ ECG ☐ MUGA ☐ BNP, NT pro BNP ☐ Device clinic reports ☐ Specialist consultation
Additional Comments:	
☐ Patient has consented to referral and information sharing with the CDMP and participating care partners.	

REFERRER'S INFORMATION:		
Referring Clinician:	Phone #:	Fax #:
Family Physician/NP:	Phone #:	Fax #:
Address:	Signature:	
Referral Date:		

Kawartha North Family Health Team
City of Kawartha Lakes Family Health Team
Haliburton Highlands Family Health Team
Community Care City of Kawartha Lakes