Phone: 415-502-4AHF (4243)
Fax: 415-502-0243

UCSF Health
Advanced Heart Failure
Comprehensive Care Center

UCSF Advanced Heart Failure Therapies
Referral for Consultation

Reason for Referral: ☐ Heart Failure Disease Management

☐ LVAD/Heart Transplant Eval ☐ Other _____

Level of Coordination Desired:

☐ Assume complete care ☐ Ongoing Management (co-management)

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Street Address: _____

City/State/Zip Code: _____

Home Phone: _____ **Cell Phone:** _____

Gender Identity: _____ **Sex Assigned as Birth:** _____

Primary Diagnosis (ICD-10): _____

_____

Primary Insurance Provider/Plan: _____

Insurance ID Number: _____ **Group Number (if applicable):** _____

Secondary Insurance Provider/Plan: _____

Insurance ID Number: _____

Insurance ID Number: _____ **Group Number (if applicable):** _____

If the patient has insurance which requires authorization, please include this with any faxed records. Please also include a copy of the front and back of the patient's insurance cards for timely processing.

Referring Provider Name: _____

Street Address: _____

City/State/Zip Code: _____

Office Phone: _____ **Office Fax:** _____

Cell Phone: _____ (*only to be provided to the UCSF physician, not part of the medical record*)

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Primary Care Provider Name: _____

Street Address: _____

City/State/Zip Code: _____

Office Phone: _____ **Office Fax:** _____

Cell Phone: _____ (*only to be provided to the UCSF physician, not part of the medical record*)

The following tests are recommended to be completed prior to the clinic appointment:

1. Echocardiogram (with copy of the CD sent).
2. Bloodwork: CBC, diff, platelets, PT, PTT, Electrolytes, BUN, Creatinine, Liver Function (Total Bilirubin, Alk Phos, AST, ALT), Calcium, Phosphorus, Magnesium, Glucose, Albumin, Total Protein.

Please fax/mail as much of the following information as possible:

- Patient demographics/facesheet
  - Include information on patient's social history, family history, and surgical history
- Insurance cards
- ECG
- Cardiac Catheterization films and report
- TransThoracic Echo (TTE) films and report
- Nuclear Medicine Studies films and report
- Office notes, discharge summaries and/or history and physical
- Previous surgery reports (CABG, Valve surgery)
- Electrophysiology studies (pacemakers, AICD)
  - If the patient has a device please include recent device interrogation report (within 3 mo) that has device serial number, type, model, and implanting physician/location information

Images can be mailed to:
Heart & Vascular Clinic
400 Parnassus Ave, Suite 501 5th Fl
ATTN: Advanced Heart Failure for UPLOAD
San Francisco, CA 94143