Guide to Heart Failure Referral

Cardiology Referral Centre or Community Cardiologist/Internist https://www.ottawaheart.ca/healthcare-professionals/referring-patient/clinical-referrals	**Advanced Heart Function Clinic** https://www.ottawaheart.ca/clinic/heart-function-clinic	**Advanced HF Therapies (VAD & Heart Transplant)** https://www.ottawaheart.ca/test-procedure/ventricular-assist-device	**Cardiac Supportive and Palliative Care** https://www.ottawaheart.ca/clinic/cardiac-supportive-and-palliative-care-program

Consider referring if a patient has **one or more** of the following:
• Primary care physician looking for plan of care
• Second admission for HF in last 12 months
• >2 visits to the ER in last 12 months
• Poor access to primary care
• Multiple (>3) chronic co-morbid diseases
• LVEF< 25%
• Kidney disease or blood pressure limitations to titration of medications
• History of poor compliance with treatment regimen
	Consider referring if a patient has **two or more** of the following:
	• Second admission for HF in last 12 months
	• >2 visits to the ER in last 12 months
	• Multiple (>3) chronic co-morbid diseases
	• LVEF< 25%
	• Kidney disease or blood pressure limitations to titration of medications
	• History of poor compliance with treatment regimen
	
	Program services include:
	• Medical assessment and follow-up
	• Personalized testing and treatment to best meet patient needs
	• Assistance with managing medication and therapies for heart failure treatment
	• Ongoing patient and family education about the disease process, diet, lifestyle, self-monitoring, and self-assessment
	• Optimization of quality of life, symptom management and prevention of hospital admissions
	• Ongoing support through follow-up visits and telephone monitoring
		Consider referring if a patient has **all** the following:
		• LVEF ≤ 25%
		• NYHA FC III or higher
		• Maximum tolerated goal directed HF therapies
		• **Plus** 1 or more of the following:
		  ○ One or more HF admissions in the past 6 months
		  ○ Hypotension with SBP < 90mmHg
		  ○ High diuretic dose (furosemide > 120mg daily)
		  ○ Recurrent appropriate ICD shocks
		  ○ Worsening renal and/or liver dysfunction
		• **Exclusion Criteria:** Advanced non-cardiac co-morbidities with <1 year anticipated survival
			Consider referring if your advanced heart failure patient requires the following:
			• Performance status poor; e.g. limited self-care; in bed or chair over 50% of the day
			• Persistent symptoms despite optimal tolerated therapy; e.g. NYHA Class III or IV
			• Two or more unplanned hospital admissions in the past 6 months for any reason
			• Two or more acute episodes needing IV diuretics and/or inotropes in the past 6 months
			• Renal impairment: eGFR less than 30mL/min/1.73m^2 or creatinine on admission greater than 200 mcmol/L
			• Cardiac cachexia: progressive loss of lean body mass; reduced muscle strength; anorexia; fatigue
			• Patients and/or families with unclear goals of care
			Program services include:
			• Symptom management
			• Goals of care discussion
			• Future care planning (e.g. advance care planning, POA, end-of-life care planning)
			• Emotional support/coping with life-threatening illness
			• Community care referral and coordination
			• Caregiver support