TODAY'S DATE (DD/MM/YYYY):

Document Version 3.0

SCOPE - MEDLY PROGRAM REFERRAL FORM

SECTION A — PATIENT INFORMATION

CLIENT NAME (Last, First): _____

DATE OF BIRTH (DD/MM/YYYY): _____

CLIENT'S EMAIL: _____

CLIENT'S PHONE NUMBER: _____

PREFERRED LANGUAGE OF COMMUNICATION: _____

CLIENT OHIP/IFH#
(please identify if uninsured) _____

PRIMARY CARE PROVIDER NAME _____

SELECT SITE: ☐ College ☐ Danforth ☐ Jane

PRIMARY CARE PROVIDER # & PREFERRED CONTACT METHOD: _____

WILL CLIENT LIKELY BE USING PROGRAM WITH SUPPORT OF A CAREGIVER:

☐ No ☐ Yes NAME AND RELATION: _____

CONTACT #: _____

NAME OF CARDIOLOGIST (If Applicable): _____

Inclusion Criteria:

- Adults with a diagnosis of Heart Failure

The program is especially useful for those who:

- Need and are receptive to self-care support and education
- Are engaged in their health management
- May need adjustments to diuretic therapy
- Could benefit from frequent weight, BP, and symptom management

Exclusion Criteria

- Client is on dialysis
- Client has current, acute conditions requiring stabilizations (i.e. stroke, STEMI, COPD), severe cognitive impairment
- Client has severe cognitive impairment
- Client has no ability to read English and has no formal or informal support to do so

SECTION B — MEDICAL INFORMATION

☐ HFrEF ☐ HFpEF

Date of last echo: _____

Ejection Fraction: _____

Please indicate whether recent clinical note or medical history has been attached to this referral form (if yes, please skip this section B): ☐ YES ☐ NO

ALLERGIES: _____

MEDICAL COMORBIDITIES:

☐ HTN ☐ CKD ☐ Mental Health

☐ COPD ☐ DMII

☐ CHF ☐ OSA

☐ Cancer: _____

If Mental Health was checked:

☐ Depression ☐ Disordered Eating ☐ Other: _____

☐ Anxiety ☐ Substance Use

MOBILITY:

☐ Full Assist ☐ Partial Assist ☐ Independant ☐ Other: _____

EQUIPMENT NEEDED: ☐ Smart Phone ☐ Weight Scale ☐ BP Cuff

SECTION C — MEDLY ALERT THRESHOLDS

WEIGHT THRESHOLDS

Weight when seen in Clinic

_____ lbs **DATE:** _____

Is Client Volume Overloaded on Assessment?

☐ YES ☐ NO

Any Additional Weight Related Information:

BLOOD PRESSURE & PULSE RANGES

Medly BP and HR ranges have a default value (see below) however they can be customized to meet patient needs

	Defaults (Circle)		Urgent Low (Will trigger Red alert)
SBP	80 mmHg	160 mmHg	_____ mmHg
DBP	40 mmHg	100 mmHg	Any Additional BP Related Information:
HR	50 bpm	110 bpm	

SECTION D — MEDLY QUESTIONS

1. **Does the client have a pacemaker?** ☐ Yes ☐ No

   IF YES, What is the pacemaker's lower rate limit: _____

2. **Were medications changed during most recent visit?** ☐ Yes ☐ No

3. **Does the client have an Implantable Cardioverter Defribrilator (ICD)?** ☐ Yes ☐ No

   IF YES, device settings: _____

4. **In response to weight gain, have you advised the client to do any of the following (ex. add PRN diuretics)?** ☐ **YES** ☐ **NO**

   ☐ A) "Follow your doc's orders to take **extra** _____ (dose) _____ (drug) Restrict salt and fluid"

   ☐ B) "Follow your doc's orders to take _____ (dose) _____ (drug) Restrict salt and fluid"

SECTION E — MEDICATIONS

Please indicate whether recent clinical note or medication list has been attached to this referral form (if yes, please skip this section E): ☐ YES ☐ NO

Medications:

☐ ACE/ARB/ARNI; name & dose: _____

☐ Beta Blocker; name & dose: _____

☐ Diuretic; name & dose:(include PRN doses): _____

☐ Other (HF and Other Conditions): _____

☐ MRA; name & dose: _____

☐ SGLT2i; name & dose: _____

PLEASE FAX COMPLETED FORM TO:
(416) 340-4134 AND EMAIL:
stella.kozuszko@uhn.ca to notify of referral