Hospital Clínica Bíblica

Su salud integral... nuestra principal preocupación

Patient reference to the Heart Failure Program
Clínica Bíblica Hospital

Dear Physician, please enclose any other information you may deem relevant together with this form on the back or else as attached documents.

Patient´s Name: _____ Identification number: _____
Medical Center that refers_____
Attendant physician: _____Telephone no._____

Pathological background:

Surgical background:

Other background:

Allergies: _____

Laboratory

Date of last control:_____

Hb:	Glycemia:
Ht:	HbA1c:
Na:	CPK total:
K:	CK-MB:
Cl:	TP:
Mg:	TPT
NU:	INR:
Creatinine:	BNP:
ALT:	Proteins:
AST:	Alkaline phosphatase:
C- LDL:	Bilirubin:
C- HDL:	Total Bilirubin:
Cholesterol:	
Total Cholesterol:	

Medical devices implanted

Date of last ECHO: _____EFV:_____

Cause of the HF: _____

Beginning date of HF symptoms: _____

Functional Class NYHA: ( ) I ( ) II ( ) III ( ) IV

Stages according to ACC/AHA: ( ) A ( ) B ( ) C ( ) D

Current medical treatment:

Dear Patient, to obtain further information please call 2522 1000, ext. 3310 or 4302