



**Florida  
Health Care  
Plans**



An Independent Licensee of the Blue Cross and Blue Shield Association

**COMPLEX CARE / CHF REFERRAL**

Referral Source: \_\_\_\_\_ EXT \_\_\_\_\_  
(Name)

Patient Name: \_\_\_\_\_ Med Rec #: \_\_\_\_\_ PCP: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_ Cardiologist \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

**Relevant Diagnosis – all that apply (✓)**

- Diabetes I or II
- COPD/Asthma
- CAD
- ESRD
- PVD
- CHF (NYHA Class)
- Others (list) \_\_\_\_\_

**Risk Factors**

- Hx. Falls
- Lives Alone
- Confused
- Not Aware of Dx
- Other \_\_\_\_\_
- Medication Compliance
- HTN
- Afib
- Hyperlipidemia
- Mental Health Dx.
- Other \_\_\_\_\_

**NYHA Classification (For CHS Diagnosis):** (Symptoms of SOB, fatigue, chest pain or leg pain).

- I: Not resulting with any physical activity.
- II: With ordinary physical activity. Patient is comfortable at rest.
- III: With < ordinary physical activity (<1 or 2 blocks level walking).
- IV: With any physical activity or at rest.

**Include dates of hospitalization (when & where, ER, UC, OV) within the last 6 months, if known.**

\_\_\_\_\_  
\_\_\_\_\_

**Include with Referral:**

- H & P
- Most recent specialist dictation (i.e. Cardiology, Pulmonology, Oncology, Nephrology, etc.)
- EF %, Echogram, Cardiac Catheterization dictation, etc.
- Medication List
- Any additional information \_\_\_\_\_

**Completed By:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Send to:**  
Case Management Department  
Florida Health Care Plans  
1340 Ridgewood Avenue  
Holly Hill, FL 32117

Phone # 386/676-7187  
Fax #: 386/615-4058