Congestive Heart Failure Referral	Referral Guide: 	**Cardiology**

Diagnosis/Definition:

Clinical syndrome with symptoms of shortness of breath, fatigue, and signs of elevated jugular venous pressure, rales, displaced PMI, S4, S3, and lower extremity edema.

Systolic dysfunction – congestive heart failure (CHF) with decreased left ventricular ejection fraction (LVEF) <40%. Common causes are coronary artery disease (CAD), hypertension (HTN), idiopathic dilated cardiomyopathy and alcohol abuse.

Diastolic dysfunction – normal LVEF>55% with elevated filling pressures. Common causes are CAD, HTN, diabetes mellitus, and aortic stenosis.

Initial Diagnosis and Management:

12 lead electrocardiogram
PA and LAT CXR
Transthoracic echocardiogram (CHCS: ORE->RAD->Echo)
Labs – CBC, chem. 7, albumin, lipids, LFTs, UA, thyroid function (if Abif or unexplained failure)

Initial Management:

Hospitalize if: first episode of moderate to severe heart failure, or recurrent heart failure complicated by acute events or myocardial infarction (MI), pulmonary embolism (PE), acute pulmonary edema, hypotension, symptomatic arrhythmias.

LV systolic dysfunction:

ACE-1 at max doses (if contraindicated, use angiotensin II blocker), digoxin, diuretic for congestion, anticoagulation (if Afib or h/o embolization), beta-blocker (if volume compensated, start low and titrate slowly).

Other: 2Gm sodium restricted diet, dynamic exercise as tolerated.

LV diastolic dysfunction.

ACE-1 and beta-blockers. Consider diuretic, nitrates.

Digoxin and other positive inotropic agents are not indicated.

Ongoing Management and Objectives:

Stabilization of symptoms with attention to common management errors.

Inappropriate medical therapy: no ACE-1 or inappropriate doses, inadequate diuretic dose, deleterious effects of CaCB (in systolic dysfunction) use of NSAIDs, inadequate BP control (SBP 90-100), untreated tachycardia (ventricular rate goal 60-80bpm).

Dietary noncompliance: >2 Gm sodium, alcohol and nicotine use.

Untreated comorbidities: infection, anemia, thyroid, and nutritional deficiencies. Consider evaluation for associated CAD.

All patients referred to Heart Failure Education Class. (CHCS: New Order > CON> M Heart Failure Ed Class)

Disclaimer: Adherence to these guidelines will not ensure successful treatment in every situation. Further, these guidelines should not be considered inclusive of all accepted methods of care or exclusive of other methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding the appropriateness of any specific procedure, therapy, or referral must be made by the physician/provider in light of all circumstances presented by an individual patient.

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Indications for Specialty Care Referral:

Recurrent CHF symptoms and/or hospitalizations despite appropriate medical therapy.
Need for ischemia evaluation.
Assistance with medical therapy if presence of acute renal failure, consideration of other meds such as Carvedilol and/or drug studies.

Test(s) to Prepare for Consult:	**Test(s) Consultant May Need To Do:**

Criteria for Return to Primary Care:

Stabilization of symptoms on medications.
Any required evaluation or treatment for CAD accomplished.

Revision History: Created Revised

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