

# HEART FAILURE PHYSICIAN QUERY FORM

*THIS FORM IS A PERMANENT PART OF THE MEDICAL RECORD*

Date: \_\_\_\_\_

Dear Dr. \_\_\_\_\_:

**Please return this form by fax to:  
XXX-XXX-XXXX**

In responding to this query, please exercise your independent professional judgment. The fact that a question is asked does not imply that any particular answer is desired or expected. Thank you for your clarification on this documentation.

Coder's Name: \_\_\_\_\_ Coder's Phone #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

MR#: \_\_\_\_\_ Acct #: \_\_\_\_\_

**The medical record reflects the diagnosis of Heart Failure (e.g. Congestive, left, etc.) in the** (list source document(s)):

**And pertinent studies (e.g. echocardiogram, cardiac catheterization, etc.) and/or findings of potential clinical abnormalities (e.g. physician documents an abnormal EF) shows** (specify results identified):

Please respond to the following question and take the appropriate action based on your response:

**Based on the above information, can you identify the specific type (e.g. diastolic, systolic, etc.) and acuity level (e.g. acute, chronic, acute on chronic, or unspecified) of the patient's Heart Failure?**

If yes, please document the type and acuity level of the Heart Failure in the space below and/or in the medical record (progress notes, dictated report or as an addendum to a dictated report), sign and date.

If no, please initial in or check the box, sign and date.

If unable to determine, please initial in or check the box, sign and date.

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE