Heart failure with increasing oedema: referral

Original independent practice material. Patient details, observations and individual GP instructions are fictional case facts; general safety advice is labelled separately. Assume that today is 4 November 2026. You have assessed Mr Bernard Farell at home. Allow 45 minutes: 5 minutes for reading and 40 minutes for writing. You are a registered nurse in the community nursing service. Using the case notes, write a referral letter to Ms Keely Dasey, Heart Failure Specialist Nurse, Community Rapid-Review Service, 42 Station Road, SW1V 2AB, United Kingdom. Request assessment today of Mr Bernard Farell's worsening symptoms, explaining his transport barrier and the GP's instructions concerning his existing prescriptions. In your answer: expand the relevant notes into complete sentences; do not use note form; use letter format. The body of the letter should be approximately 180–200 words.

Choose one box per line: I = Include / C = Compress / O = Omit. Answers and reasons are on the webpage (scan QR).

	I	C	O
Patient details			
1. Name: Mr Bernard Farell	☐	☐	☐
2. DOB: 18/03/1950 (76 yrs)	☐	☐	☐
3. Address: 18 Orchard Road, SW1V 2AD, United Kingdom	☐	☐	☐
4. Community nursing assessment: 04/11/26; referral written today	☐	☐	☐
Social background			
5. Lives alone; independently manages medicines and personal care	☐	☐	☐
6. Daughter usually drives him to appointments; unavailable this week	☐	☐	☐
7. No alternative transport; cannot attend clinic today; agrees to home assessment	☐	☐	☐
8. Retired accountant; enjoys collecting old postcards	☐	☐	☐
9. Complained that reception staff sounded bored during his telephone call	☐	☐	☐
Medical history			
10. Chronic heart failure diagnosed 2023; usually stable	☐	☐	☐
11. Hypertension; under regular GP care	☐	☐	☐
12. Appendicectomy 1968; uncomplicated recovery	☐	☐	☐
13. Medicines reconciled today; complete current prescription list enclosed	☐	☐	☐
14. Reports taking prescribed furosemide consistently; no missed doses	☐	☐	☐
Assessment and symptom trend			
15. Weight: 01/11 78.2 kg → 04/11 80.6 kg	☐	☐	☐
16. Ankle oedema now reaches both shins; increasingly breathless walking indoors	☐	☐	☐
17. Usual shoes now tight; previously comfortable	☐	☐	☐
18. Comfortable at rest; no chest pain, orthopnoea or syncope	☐	☐	☐
19. Alert; speaking full sentences; no visible respiratory distress	☐	☐	☐
20. BP 118/72 mmHg; pulse 78 regular; RR 18; SpO2 96% room air	☐	☐	☐
21. Food and fluid intake unchanged; no vomiting	☐	☐	☐
22. No recent fever or cough	☐	☐	☐
23. No new medicines; denies taking non-prescription anti-inflammatory medicines	☐	☐	☐
24. Weights recorded each morning using same scales	☐	☐	☐
25. No prescribed flexible diuretic self-adjustment plan	☐	☐	☐
26. Consents to referral and sharing assessment with GP	☐	☐	☐
Plan: individual GP instructions unless labelled otherwise			
27. GP reviewed symptoms by telephone: requests home assessment today; if unavailable, contact GP today for alternative assessment	☐	☐	☐
28. GP: continue current prescriptions pending review; diuretic changes require prescriber assessment	☐	☐	☐
29. Report assessment to GP today; explore transport support for future appointments	☐	☐	☐
30. General safety advice given: call 999 for severe breathing difficulty or collapse with abnormal responsiveness	☐	☐	☐