Valve Clinic Referral Form

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PATIENT INFORMATION - PLEASE COMPLETE	
Patient name:	
Address:	
Phone number:	
DOB:	
Health card #:	

REASON FOR REFERRAL

AORTIC STENOSIS:

☐ To evaluate a patient with severe symptomatic AS for possible Transcatheter Aortic Valve Replacement due to:

- ☐ Age ≥ 75
- ☐ Prior CABG/sternotomy
- ☐ Failing Bioprosthetic Aortic Valve
- ☐ Severe Comorbidity (Lung, Liver, etc)

☐ To evaluate a symptomatic patient with uncertainty regarding the severity of AS (usually due to discordance between valve area and gradient).

☐ To evaluate a patient with severe AS with uncertainty regarding symptom status

☐ Other – please specify_____

MITRAL REGURGITATION:

☐ To evaluate a patient with severe symptomatic MR for possible Transcatheter Mitral Clip with:

☐ Functional MR ☐ Degenerative MR

☐ To evaluate a symptomatic patient with uncertainty regarding the severity of MR

☐ To evaluate a patient with severe MR with uncertainty regarding symptom status

☐ Other – please specify_____

MITRAL STENOSIS:

☐ To evaluate a patient with severe symptomatic MS for possible Transcatheter Balloon Valvuloplasty

TRICUSPID REGURGITATION:

☐ To evaluate a patient with severe symptomatic tricuspid regurgitation for possible Percutaneous treatment

COMPLEX VALVE DISEASE ASSESSMENT:

☐ To evaluate a patient with multiple valve pathologies for symptom status or severity

REFERRING PHYSICIAN INFORMATION - PLEASE COMPLETE		
Referring Physician:	Signature:	
Billing Number:	Office Address:	City:
Phone Number:	Fax Number:	Postal Code:
Copies of reports to	Date: MM DD YYYY	

PLEASE INCLUDE ALL RELEVANT CONSULTATIONS AND INVESTIGATIONS
REFERRALS ARE ACCEPTED BY FAX OR EMAIL