St. Mary's REGIONAL CARDIAC CARE CENTRE

911 Queen's Blvd
Kitchener, ONT N2M 1B2

Health Record # Insert patient label
OHIP #: _____
Patient Name: _____
DOB: ____/____/_____ Age: ☐ Female ☐ Male
Account: _____ Date of Admission: ___/___ /___

Transcatheter Aortic Valve Implantation (TAVI) Referral

Please fax to 519-749-6414
TAVI Triage Nurse/Coordinator 519-749-6578 x1992

TAVI is intended for patients with symptomatic **severe** aortic stenosis that are considered to be at **high operative risk** for surgery, **or inoperable.**

Patient Name: PRINT (first, last)	
Patient Address:	
Patient Preferred Phone Number:	Patient Alternate Phone Number:
Primary Care Physician Name: (if different from referring physician)	
Primary Physician Contact Number:	

This patient has: LVEF: _____ %
NYHA functional class: ☐ 1 ☐ 2 ☐ 3 ☐ 4
CCS Angina Class: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Factors contributing to high operative risk for this patient:

- ☐ Age greater than 80
- ☐ Frailty
- ☐ Previous cardiac surgery
- ☐ Cognitive impairment
- ☐ Severely calcified aorta
- ☐ Cerebrovascular disease (CVA with significant deficits)
- ☐ Mediastinal irradiation
- ☐ Other significant co-morbidities _____

I have discussed with the patient:

- The need for further tests and clinic visits. (ie: TEE, CT scan and possible repeat catheterization/aortogram)
- May be referred for surgical AVR after assessment by TAVI team

☐ Yes ☐ No

PLEASE INCLUDE THE FOLLOWING REPORTS:

- Recent consult note
- Echocardiogram report
- Medication list
- Cardiac catheterization
- Recent blood work
- CT scans, PFT's (if done)

BY SIGNING THIS FORM, I confirm that this patient is aware of this referral.

Referring Physician Name: (PRINT)	Billing#:
Referring Physician Signature	Date: _____ /_____ / _____
Phone Number:	Fax Number:

CLINIC USE ONLY

Date referral received: _____ /_____ / _____	APPOINTMENT: DATE: _____ Time: _____

Created May 31, 2018