Centre for
Heart Valve Innovation
St. Paul's Hospital, Vancouver

Providence Health Care
Heart Centre

Vancouver Transcatheter Heart Valve Program

St. Paul's Hospital - 1081 Burrard Street
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Email: TranscatheterValve@phc.ca

REFERRAL FORM – Evaluation for a Transcatheter Heart Valve Procedure

Date: Number of pages (TOTAL):

PATIENT INFORMATION: **Current Patient Status:** ☐ **Outpatient** ☐ **Inpatient**

Name: _____ Address: _____

DOB: _____ City: _____ Postal Code: _____

PHN: _____ Email: _____

Primary number: _____ Secondary number: _____

Primary Care Provider: _____

Referring provider: _____

Referring fax #: Referring phone #:

VALVULAR HEART DISEASE TYPE: (Please check)	
☐ Transcatheter Aortic Valve Implantation	☐ AS ☐ AR ☐ Previous aortic valve replacement
☐ Transcatheter Mitral Valve procedure	☐ MS ☐ MR ☐ Previous mitral valve replacement
☐ Transcatheter Tricuspid Valve procedure	☐ TS ☐ TR ☐ Previous tricuspid valve replacement
☐ Balloon Valvuloplasty procedure	
Comments:	

REFERRAL DOCUMENTS: (Please check if included)
☐ Recent medical history and/or consult within 1 year
☐ Cardiac echo report within 1 year
☐ Recent blood work report: eGFR/Cr, Hgb, NT-proBNP
☐ Recent Electrocardiogram
☐ Other consults (e.g. surgical, geriatric, oncology, respiratory medicine, pulmonary function test etc.)

Please send referral to:

FAX: 604-806-9878

OR

EMAIL: TranscatheterValve@phc.ca

Referral receipt will be faxed to the referring provider