Providence Health Care

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Place Patient Form Label Here

SPH TRANSCATHETER HEART VALVE PROGRAM REFERRAL FORM – EVALUATION FOR A TRANSCATHETER HEART VALVE PROCEDURE

* 4 0 3 6 *

Cardiology Referral

Date: Number of pages (TOTAL):

PATIENT INFORMATION:

Name: _____

DOB (dd/mmm/yyyy): _____

PHN: _____

Primary phone number: _____

Primary Care Provider: _____

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

Address: _____

City: _____ Postal Code: _____

Email: _____

Secondary phone number: _____

Referring provider: _____

Referring fax number: _____ 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 completed referral to:
FAX: 604-806-9878
OR
EMAIL: TranscatheterValve@phc.ca

Referral receipt will be faxed to the referring provider