SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Regional Cardiac Care Program
(905) 895-4521, Ext. 2546

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Transcatheter Aortic Valve Implantation (TAVI) Referral

Please Fax to: (905) 952-2445

TAVI is intended for patients with symptomatic SEVERE aortic stenosis.

Patient Name: *(print first, last)*

Address:

Contact Number: | **Would you prefer us to call your Primary Contact?** ❑ Yes ❑ No

Primary Contact: *(print first, last)* | **Relationship to patient:**

Contact Number:

Primary Care Physician - *if different from Referring Physician: (print first, last)*

Phone Number: | **Fax Number:**

THIS PATIENT HAS:

NYHA Functional Class: ❑ I ❑ II ❑ III ❑ IV

LVEF: _____ **%**

CCS Angina Class: ❑ 0 ❑ I ❑ II ❑ III ❑ IV

HIGH OPERATIVE RISK FACTORS:

Significant co-morbidities: _____

_____

_____

❑ I have discussed with the patient that they can expect to undergo several investigations to assess aortic valve and root, aortic arch, abdominal aorta, iliac and femoral vessels. Tests will include a CT scan and possible repeat catheterization/ aortogram.

PLEASE INCLUDE THE FOLLOWING REPORTS:

Please do not order diagnostic tests such as TEE, CT, or catheterization in conjunction with the TAVI referral. Patient's will be reviewed in the TAVI clinic first and additional diagnostic tests will be ordered by the TAVI Team thereafter.

- Recent Consult Notes
- Medication List
- Recent Bloodwork
- Cardiac Cath (if done)
- CT Scans, PFTs (if done)
- Echo Report

Referring Physician Name: *(print first, last)* | **Billing #:**

Signature: | **Date:** dd / mm / yy

Phone Number: | **Fax Number:**