STRUCTURAL HEART CLINIC

Scarborough Health Network, Centenary Site
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Scarborough, Ontario M1E 4B9
Phone: (416) 284-8131 ext. 7504
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SHN
SCARBOROUGH HEALTH NETWORK

COMPLETE OR PLACE PATIENT LABEL HERE

Patient Name: _____

DOB: _____ Age: _____

OHIP #: _____ ☐ Male ☐ Female

Transcatheter Aortic Valve Implantation (TAVI) Referral

TAVI is intended for patients with SEVERE aortic valve disease

Patient Name: *(last name, first name)*	
Address:	
Contact Number:	**Would you prefer us to call your Primary Contact?** ☐ Yes ☐ No
Primary Contact: *(last name, first name)*	**Relationship to patient:**
Primary Contact Number:	
Primary Care Physician – *if different from Referring Physician*: *(last name, first name)*	
Phone Number:	**Fax Number:**

THIS PATIENT HAS: ☐ Severe Aortic Stenosis ☐ Failing Bioprosthetic Aortic Valve ☐ Other _____	**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 catherization/aortogram.**

PLEASE INCLUDE THE FOLLOWING REPORTS:

We will arrange any necessary further investigations, such as TEE, CT, or catherization in conjuction with the TAVI referral.

Patients will be reviewed in the clinic first and additional diagnostic tests will be ordered thereafter.

- Recent Consult Notes
- Medication List
- Recent Bloodwork
- ECG Tracing *(if available)*
- Cardiac Cath *(if available)*
- CT Scans, PFTs *(if available)*
- Echo Report *(if available)*

Referring Physician Name: *(last name, first name)*	**Billing #:**
Signature:	**Date:**
Phone Number:	**Fax Number:**

PLEASE FAX REFERRAL AND SUPPORTING DOCUMENTS TO (416) 281-7333

RECEIPT OF REFERRAL AND NOTIFICATION OF APPOINTMENT WILL BE CONFIRMED WITHIN 2 WEEKS