SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Regional Cardiac Care Program

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

Valvular Heart Disease Referral

PLEASE COMPLETE FORM AND FAX WITH RELEVANT DOCUMENTATION TO (905) 952-2443

PATIENT DEMOGRAPHICS:

Patient Name: *(print first, last)*

Date of birth: dd / mm / yy **Health card number:**

REASON FOR REFERRAL/ INTERVENTION REQUESTED:

If patient is deemed surgical, please specify: Preferred Surgeon: ______________ ❑ first available

VALVE PATHOLOGY:

❑ Aortic Stenosis
❑ Aortic Regurgitation
❑ Mixed aortic valve disease
❑ Bicuspid valve

❑ Mitral Stenosis
Etiology: ❑ Rheumatic ❑ MAC ❑ Unknown
❑ Mitral Regurgitation
Etiology: ❑ Primary ❑ Secondary ❑ Mixed ❑ Unknown
❑ Mixed mitral valve disease

❑ Tricuspid Regurgitation
❑ Other: ______________

The Heart Team will review the case, make recommendations on management, further investigations, intervention and timing in collaboration with the referring physician.

SYMPTOMS:

❑ NYHA I (asymptomatic)
❑ NYHA II (Comfortable at rest; symptomatic with moderate activity)
❑ NYHA III (Comfortable at rest; symptomatic with minimal activity)
❑ NYHA IV (Symptomatic at rest or with any activity)

LV FUNCTION: *(please attach echo report)*

❑ Normal (greater than or equal to 52% ❑ Mild (41-52%) ❑ Moderate (30-40) ❑ Severe (less than 30) EF____%

RECENT HOSPITALIZATION: (WITHIN SIX MONTHS) ❑ Yes ❑ No

PREVIOUS STERNOTOMY/THORACOTOMY: ❑ Yes ❑ No **PREVIOUS VALVE INTERVENTION:** ❑ Yes ❑ No

COMORBIDITES: *(please tick all that apply)*

❑ CAD ❑ PVD ❑ CVD ❑ LIVER DISEASE ❑ CKD ❑ MALIGNANCY ❑ COPD ❑ FRAILTY
❑ COGNITIVE IMPAIRMENT

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR FAXED REFERRAL, IF AVAILABLE:

- **Relevant medical history including notes on above comorbidities**
- **Imaging studies** (within the last 6 months, Echo, CT, Angiogram)
- **Current medications**
- **Recent bloodwork**
- **Other relevant diagnostics** (PFTS, stress test etc.)
- **Recent discharge summary**

ADDITIONAL COMMENTS:

Referring Provider Name: **Date:** dd / mm / yy

Fax number: **Phone number:** **Email:**

S-VALHDR