

Health Record #:	_____ Complete or place barcoded patient label here		
Patient Name: <i>(Print first, last)</i>	_____		
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
OHIP #:	Version Code: _____		
Account #:	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>		

Valvular Heart Disease Referral

PLEASE COMPLETE FORM AND FAX WITH RELEVANT DOCUMENTATION TO (905) 952-2467

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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Aortic Stenosis | <input type="checkbox"/> Mitral Stenosis | <input type="checkbox"/> Tricuspid Regurgitation |
| <input type="checkbox"/> Aortic Regurgitation | Etiology: <input type="checkbox"/> Rheumatic <input type="checkbox"/> MAC | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Mixed aortic valve disease | <input type="checkbox"/> Unknown | |
| <input type="checkbox"/> Bicuspid valve | <input type="checkbox"/> Mitral Regurgitation | |
| | Etiology: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary | |
| | <input type="checkbox"/> Mixed <input type="checkbox"/> Unknown | |
| | <input type="checkbox"/> Mixed mitral valve disease | |

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

SYMPTOMS:

- | | |
|--|--|
| <input type="checkbox"/> NYHA I (asymptomatic) | <input type="checkbox"/> NYHA III (Comfortable at rest; symptomatic with minimal activity) |
| <input type="checkbox"/> NYHA II (Comfortable at rest; symptomatic with moderate activity) | <input type="checkbox"/> 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

COMORBIDITIES: *(please tick all that apply)*

-
- CAD
-
- PVD
-
- CVD
-
- LIVER DISEASE
-
- CKD
-
- MALIGNANCY
-
- COPD
-
- FRAILITY
-
-
- COGNITIVE IMPAIRMENT

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

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

ADDITIONAL COMMENTS:

Referring Provider Name: _____

 Date: dd / mm / yy

Fax number: _____

Phone number: _____

Email: _____

