SWEDISH
MEDICAL GROUP

Swedish Heart &Vascular
TAVR Program
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Date: _____
Referring MD: _____
MD contact number_____
Facility name: _____
Primary contact: _____
Direct number(s): _____

Requesting consultation for:

□ Aortic valve disease/Transcatheter aortic valve replacement (TAVR)
□ Mitral valve disease/Balloon mitral valvuloplasty/Percutaneous mitral valve repair (Mitraclip)
□ Left atrial appendage occlusion (WATCHMAN/SENTREHEART) for atrial fibrillation/high risk anticoagulation
□ Patent Foramen Ovale (PFO)/Atrioseptal Defect (ASD)/Patent Ductus Arteriosus (PDA)/Ventricular Septal Defect (VSD)
□ Coronary artery disease/Rotational atherectomy/Chronic totally occluded (CTO) coronary artery
□ Carotid artery disease/Carotid artery stenting
□ Consultation/ Second opinion _____

Patient name: _____
DOB: _____
Phone number(s): _____
Address: _____
City: _____ Postal Code_____
Alternative contacts: _____
Insurance: _____
ID/Group numbers: _____

Please check the applicable records with this referral below:

□ Demographics
□ Copies of Insurance Card(s) front & back
□ History and Physical
□ PFT's
□ Carotid Duplex
□ Transthoracic Echocardiogram *
□ Transesophageal Echocardiogram *
□ CT and/or CT Angiogram *
□ Cardiac Catheterization *
□ EKG
□ Most recent blood work (CBC, BMP, Lipids, Coagulation Studies)
□ Relevant operative reports (e.g., CABG) or consults (cardiac surgery/pulmonology/heme/oncology)

*Please send images/CDs on studies above to the SHD/TAVR Program
Date images were mailed/Fedex/UPS _____

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