Center for Advanced Valve and Structural Heart Care Referral Form

Complete this form and fax to (727) 462-7261 or call the coordinator at (855) 44-VALVE (855-448-2583).

Patient Information

Name: _____ Date: _____

Phone: _____ Date of birth: _____ Social Security number: _____

E-mail: _____

Address: _____

Primary insurance: _____ Secondary insurance: _____

Primary care physician: _____

Allergies: _____

Notes: _____

Diagnosis

❑ Aortic disease ❑ Mitral disease ❑ Tricuspid disease ❑ Pulmonic disease ❑ PFO ❑ ASD ❑ Paravalvular leak

❑ Other _____

Services

The coordinator can arrange for patients to have services prior to their appointment. Using the check boxes below, please note which services you would like the coordinator to arrange. For those services that have already been completed, please forward all results to the coordinator. **Testing should be current (completed within 90 days of appointment).**

Echo: ❑ TTE ❑ TEE (MitraClip only) Labs: ❑ CBC ❑ CMP ❑ PT ❑ PTT ❑ INR

❑ CTA TAVR Protocol ❑ Room Air ABG

❑ Cardiac Cath (right and left) ❑ Carotid US

❑ PFTs (Spirometry and Diffusion Capacity)

❑ _____

❑ _____

All notes and results of studies will be provided to the referring physician and the primary care physician.

Referring Physician Information

Name: _____

Please indicate the best way for a physician to contact you.

❑ E-mail: _____

❑ Cell phone: _____ ❑ Office phone: _____

Physician signature: _____

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Morton Plant Hospital
BayCare Health System