ST. MICHAEL'S
UNITY HEALTH TORONTO

Structural Heart Program Referral Form

30 Bond Street, Suite 8-003
Toronto, Ontario M5B 1W8
TEL: 416-864-5442 FAX: 416-864-5768 Email: StructuralHC@smh.ca

PATIENT'S LAST NAME:	**FIRST NAME:**	**DATE OF BIRTH: DD/MM/YYYY**		
ADDRESS:	**APT#:**	**CITY:**	**POSTAL CODE:**	**HOSPITAL MRN:**
HOME NUMBER:	**CELL/OTHER NUMBER:**	**HEALTH CARD NUMBER:**	**VERSION CODE:**	**SEX:** **M F**

URGENCY: ☐ URGENT: LESS THAN 2 WEEKS ☐ ELECTIVE: 3-6 WEEKS ☐ NON-URGENT >6WEEKS

REASON FOR REFERRAL - VALVULAR HEART DISEASE TYPE:		
☐ Transcatheter Aortic Valve Replacement (TAVR)	☐ Aortic Stenosis ☐ Aortic Regurgitation	Comment:
☐ Transcatheter Mitral Valve Repair (MitraClip or Replacement)	☐ Mitral Regurgitation ☐ Mitral Stenosis	Comment:
☐ Transcatheter Tricuspid Valve Repair (TriClip or Replacement)	☐ Tricuspid Regurgitation	Comment:
☐ Left Atrial Appendage Closure	☐ Atrial Fibrillation	Comment:

CLINICAL INFORMATION:

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PLEASE INCLUDE THE FOLLOWING REPORTS AND CDS (IF AVAILABLE):
. RECENT CONSULT NOTES . ECHO (TTE/TEE) . CARDIAC CATH .CT SCAN .RECENT BLOODWORK .MEDICATION LIST

REFERRING PHYSICIAN NAME: (PRINT)	**BILLING #:**	**PHONE#:**	**FAX#:**
ADDRESS:	**CITY:**	**POSTAL CODE:**	
REFERRING PHYSICIAN SIGNATURE:		DATE: ______/_________/_________	

CLINIC USE ONLY

DATE REFERRAL RECEIVED:	APPOINTMENT: DATE:_________________________ TIME:______________________