WRHN
@ Queen's Blvd.
Waterloo Regional Health Network

Health Record # Insert patient label
OHIP #: _____
Patient Name: _____
DOB: ____/____/_____ Age: ☐ Female ☐ Male
Account: _____ Date of Admission: ___/___ /___

Transcatheter Aortic Valve Implantation (TAVI) Referral Please fax to 519-749-6414

TAVI Triage Nurse/Coordinator 519-749-6578 x1992

To request a TAVI consultation at SMGH, please fax this form, along with the information noted below to 519-749-6414.

Patient Name: PRINT (first, last)	
Patient Address:	
Patient Preferred Phone Number:	Patient Alternate Phone Number:
Primary Care Physician Name: (if different from referring physician)	
Primary Physician Contact Number:	

This patient has: LVEF: _____ % NYHA functional class: ☐ 1 ☐ 2 ☐ 3 ☐ 4 CCS Angina Class: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Significant co-morbidities to consider for this patient: (if applicable)

- ☐ Chronic Renal Failure
- ☐ Frailty
- ☐ Previous cardiac surgery
- ☐ Cognitive impairment
- ☐ Severely calcified aorta
- ☐ Cerebrovascular disease (CVA with significant deficits)
- ☐ Chronic Liver Disease
- ☐ Other significant co-morbidities _____

I have discussed with the patient:

- The need for further tests and clinic visits. (ie: TTE, CT scan and cardiac catheterization)
- May be referred for surgical AVR after assessment by TAVI team ☐ Yes ☐ No

PLEASE INCLUDE THE FOLLOWING REPORTS:

- Recent consult note
- Echocardiogram report
- Medication list
- Cardiac catheterization
- Recent blood work
- CT scans, PFT's (if done)

BY SIGNING THIS FORM, I confirm that this patient is aware of this referral.

Referring Physician Name: (PRINT)	Billing#:
Referring Physician Signature	Date: _____ /_____ / _____
Phone Number:	Fax Number:

Questions regarding this referral can be directed to:

Rebecca Gies RN, BScN
Regional Cardiac Care Coordinator
TAVI Program
Phone: 519-749-6578 x1992
Fax: 519-749-6414
Email: rebecca.gies@wrhn.ca

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