Transcatheter Aortic Valve Replacement (TAVR/TAVI) Referral Form

SWEDISH MEDICAL GROUP

Start Date: _____ **Referral Type:** ☐ Consult Only ☐ Evaluate & Treat **Authorization Required?** ☐ Yes ☐ No

End Date: _____ **Authorization Number:** _____ **Number of Visits:** _____

Referring Provider: _____	Primary Contact: _____
Facility Name: _____	Contact Phone: _____
Phone Number: _____	Fax Number: _____

Patient Name: _____	Home Phone Number: _____
DOB: _____ SSN: _____	Alternate Phone Number: _____
Primary Contact: _____	Address: _____
Contact Phone Number: _____	_____

Please complete the insurance section below if card copies (front & back) are not available.

Primary Insurance: _____	Secondary Insurance: _____
Phone Number: _____	Phone Number: _____
ID: _____	ID: _____
Group: _____	Group: _____
Additional Insurance: _____	
Phone Number: _____	
ID: _____	
Group: _____	

Please send the following information to ensure timely scheduling. Cross out any options that do not apply.

- Completed referral form
- Completed Provider & Facility history form
- Insurance Card Copies (Front & Back)
- Authorization Approval if Obtained
- H&P and recent Office Visits Notes
- Relevant Operative Reports (e.g. CABG)
- Recent blood work (including CBC, BMP/CMP, Lipid, & Coagulation results)
- EKG
- PFT Report
- Carotid Duplex Report
- CT/CT Angiogram Reports & Images
- Transthoracic Echocardiogram (TTE) Reports & Images
- Transesophageal Echocardiogram (TEE) Reports & Images
- Cardiac Catheterization Reports & Images

Method of Shipping images/films: _____

Tracking Number: _____

Send Date: _____

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