Providence SWEDISH

Swedish Medical Group

P 206-215-4545
F 206-233-7472

Structural Heart Disease Program Referral Form

START DATE	END DATE	AUTHORIZATION REQUIRED? ☐ YES ☐ NO
REFERRAL TYPE ☐ CONSULT ONLY ☐ EVALUATE & TREAT	AUTHORIZATION NUMBER	NUMBER OF VISITS

Referring Provider: _____

Primary Contact: _____

Facility Name: _____

Contact Phone: _____

Phone Number: _____

Fax Number: _____

PATIENT NAME	DOB	SSN
PRIMARY PHONE NUMBER	PRIMARY CONTACT & PHONE NUMBER *(IF OTHER THAN PATIENT)*	
ALTERNATE PHONE NUMBER	MAILING ADDRESS	

Requesting consultation for:

- ☐ Aortic stenosis and regurgitation: transcatheter aortic valve replacement (TAVR), femoral and alternative access
- ☐ Mitral regurgitation: transcatheter mitral valve repair, transcatheter mitral valve replacement
- ☐ Mitral stenosis: balloon mitral valvuloplasty, transcatheter mitral valve replacement
- ☐ Tricuspid regurgitation: transcatheter tricuspid valve repair, transcatheter tricuspid valve replacement
- ☐ Prosthetic valve/ring dysfunction: transcatheter valve replacement (aortic, mitral, tricuspid, and pulmonic) and paravalvular leak closure
- ☐ Atrial fibrillation at high risk of stroke and bleeding: left atrial appendage occlusion
- ☐ Stroke prevention: patent foramen ovale closure, embolic protection
- ☐ Congenital heart defects: atrial septal defect closure, ventricular septal defect closure, pulmonic vein stenosis
- ☐ Hypertrophic cardiomyopathy: septal ablation
- ☐ Heart failure/Diastolic dysfunction: shunt therapy
- ☐ Fistulas/Pseudoaneurysm: fistula and pseudo
- ☐ Pulmonic valve replacement

Please complete insurance information below OR include copies of insurance card (front and back) with referral form.

Primary Insurance: _____
Phone Number: _____
Member ID: _____
Group Number: _____

Secondary Insurance: _____
Phone Number: _____
Member ID: _____
Group Number: _____

Additional Insurance: _____
Phone Number: _____
Member ID: _____
Group Number: _____

Structural Heart Program
550 17th Avenue, Suite 680, Seattle, Washington 98122

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PATIENT NAME	DATE OF BIRTH

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, Renal, MRSA & Coagulation results)
- EKG (Last two if any)
- Sleep studies or PFT Report
- Vascular Reports
- Holter Monitor, ECAT, or Event Monitor reports with tracings
- Diagnostic imaging (e.g. MRI, CXR, & Ultrasounds)
- CT/CT Angiogram Reports & Images
- Transthoracic Echocardiogram (TTE) Reports & Images
- Transesophageal Echocardiogram (TEE) Reports & Images
- Cardiac Catheterization Reports & Images
- Hospitalization records

FILM & IMAGING SHIPPING INFORMATION	
METHOD OF SHIPPING	TRACKING NUMBER
SEND DATE	NUMBER OF DISCS SENT

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HI-23-0095 5/23