

Physician Referral Form for Transcatheter Aortic Valve Replacement (TAVR)

Referral for an evaluation for the best treatment option for symptomatic Aortic Stenosis

PATIENT INFORMATION

Name _____ DOB _____

Male Female

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Alternative Contact

Name _____ Phone Number _____

Insurance _____

ID/Group Number _____

REFERRING INFORMATION

Inpatient referral? No Yes

Hospital / room number _____

Referring MD _____

Phone Number _____ Fax Number _____

Cardiologist _____

Phone Number _____ Fax Number _____

PCP _____ Phone Number _____



1135 116TH AVENUE NE SUITE 600
ATTN: VALERIE O'MARA, PA
BELLEVUE, WA 98004
PHONE: 855-895-VALV(8258) FAX: 425-635-6513
EMAIL: valveclinic@overlakehospital.org