

LVAD Referral Request

FAX: 585-276-2446

Indications for LVAD Evaluation

- Class IIIb / IV Heart Failure Symptoms Despite Medical Therapy
- LVEF < 25%
- Intolerance or withdrawal of oral heart failure agents
- Heart Failure symptoms despite resynchronization therapy

From: _____

Office Contact : _____ Phone : _____

Patient Name: _____

DOB: ____ / ____ / ____ Pt's PCP: _____

Records Faxed:

- | | |
|--|--|
| <input type="checkbox"/> Patient Information / Face Sheet | <input type="checkbox"/> Pulmonary Function Tests |
| <input type="checkbox"/> Signed Medical Information Release form (if required) | <input type="checkbox"/> Vascular Studies (carotids / ABI's) |
| <input type="checkbox"/> Last Office Visit Note | <input type="checkbox"/> Labs |
| <input type="checkbox"/> H&P | <input type="checkbox"/> Cancer Screening |
| <input type="checkbox"/> Echocardiography Report | <input type="checkbox"/> Viability Studies |
| <input type="checkbox"/> Heart Catheterization Report | <input type="checkbox"/> Previous Surgical Reports |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

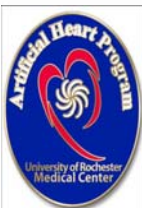
Dr Massey,

Please follow up with me via:

Phone: (____) _____ - _____ Pager (____) _____ - _____

Email: _____ @ _____

Signed _____



UNIVERSITY of
ROCHESTER
MEDICAL CENTER

MEDICINE of THE HIGHEST ORDER