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:

❑Patient Information / Face Sheet

❑Signed Medical Information Release form (if required)

❑Last Office Visit Note

❑H&P

❑ Echocardiography Report

❑ Heart Catheterization Report

❑_____

❑_____

❑Pulmonary Function Tests

❑Vascular Studies (carotids / ABI's)

❑Labs

❑Cancer Screening

❑ Viability Studies

❑ Previous Surgical Reports

❑_____

❑_____

Dr Massey,

Please follow up with me via:

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

❑ Email:_____@_____

Signed_____

Artificial Heart Program
University of Rochester Medical Center

UNIVERSITY of ROCHESTER MEDICAL CENTER
MEDICINE of THE HIGHEST ORDER