Transcatheter Heart Program
TAVR Referral Form

Please complete the form and fax to: Andrea Cronin, (914) 493- 2858
You can also complete the form electronically by visiting: www.westchestermedicalcenter.com/TAVR

Today's date: _____

Patient name (please print): _____

Patient telephone number: _____ Date of birth: _____

*Contact (if other than patient):*_____

Contact telephone number: _____

Referring physician: _____

Referring physician telephone number: _____

Email (optional): _____

Reason for referral:

☐ Urgent consultation for severe aortic stenosis

☐ Elective consultation for severe aortic stenosis

Referring physicians, please complete the following:
Patient history (check all that apply):

CVA ☐ COPD ☐ CHF ☐ Renal Insufficiency ☐ Prior Cardiac Surgery ☐

Would you like us to contact you about this patient? Yes ☐ No ☐

Would you like us to contact the patient directly to set up a consultation? Yes ☐ No ☐

Patients, please complete the following:
Have you ever been to a Westchester Heart and Vascular practice location?

Yes ☐ No ☐

Comments:

Thank you for your referral. Patients, please fax this completed form to the number provided below. Referring physicians, please fax this completed form and the patient's most recent echocardiogram report to:

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