

Referral Form

Complete this form and fax to (850) 431-6597 or call the Tallahassee Memorial Heart & Vascular Clinic at (850) 431-7397.

Name: _____ Date: _____

Phone: _____ Date of Birth: _____ Social Security Number: _____

Address: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Care Physician: _____

Allergies: _____

Notes: _____

Services for the Valve Clinic

The Valve Clinic coordinator can arrange for patients to have services prior to the Valve Clinic appointment. Using the check boxes below, please note which services you would like the valve clinic coordinator to arrange. For those services that have already been completed, please forward all results to the Valve Clinic coordinator.

Testing should be current (completed within 90 days of Valve Clinic appointment).

Echo: TTE TEE Labs: CBC CMP PT PTT INR

Carotid US

Cardiac Cath (right and left with aorto-iliac angiogram)

PFTs (Spirometry and Diffusion Capacity)

TAVR CTA (C/A/P) will be done at TMH.

All notes and results of studies will be provided to the referring physician and the primary care physician.

Referring Physician Information

Name: _____

Please indicate the best way for a Valve Clinic physician to contact you.

E-mail: _____

Cell phone: _____ Office Phone: _____

Physician Signature: _____

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Tallahassee Memorial
Heart & Vascular Center

TMH *Your Hospital for Life*