LVAD Referral Request

Please FAX to: 513-585-0385

Indications for LVAD Evaluation

Check any/all that apply

- ☐ 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
- ☐ Inability to walk one block without shortness of breath
- ☐ One or more heart failure-related hospital admissions in the past six months

---

From: ____________________

Office Contact: ____________________ Phone: ____________________

Patient Name: ____________________

DOB: ____________________ PCP: ____________________

Insurance: ____________________

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/ABIs)
- ☐ Labs
- ☐ Cancer screening
- ☐ Viability studies
- ☐ Previous surgical reports
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

Doctor

Please follow up with me via:

Phone: ____________________

Pager: ____________________

Email: ____________________

Signed ____________________

The Christ Hospital

Mechanical Heart Assist Device Program

Office 513-585-4944 • Pager 859-572-1609

Cell 859-620-5609

Please fax or email to:

MHAD@TheChristHospital.com

B153-1210