

THE RBHT MITRACLIP CtE REFERRAL FORM

Please refer to Prof Carlo Di Mario / Dr Rob Smith

**email to Michele Moore, m.moore2@rbht.nhs.uk or Leah Martin L.martin2@rbht.nhs.uk
or phone 01895 828990 / fax 01895 826581**

Patient Name:	GP Name:
Date of birth:	GP Address:
NHS number:	
Referring Hospital:	
Referring Consultant:	

Please confirm the following clinical and echocardiographic details:

Grade of mitral regurgitation (1-4)	
Degenerative or functional mitral regurgitation	
Evidence of mitral stenosis: Yes or No	
Ejection fraction (%)	
Patient deemed as too high risk for conventional mitral valve surgery : Yes or No	
On optimal medical therapy: Yes or No	
Patient evaluated for CRT : Yes or No	
Life expectancy > 12 months: Yes or No	

Current clinical status:

In-patient or Out-patient:

If out-patient, hospitalisation in last 12 months with HF?

Current NYHA class:

Current Angina CCS:

Height (cm)

Weight (kg)

THE RBHT MITRACLIP CtE REFERRAL FORM

Please refer to Prof Carlo Di Mario / Dr Rob Smith

**email to Michele Moore, m.moore2@rbht.nhs.uk or Leah Martin L.martin2@rbht.nhs.uk
or phone 01895 828990 / fax 01895 826581**

Body Surface Area:

Body Mass Index:

Major Frailty/Mobility issues?

Current medication:

Indicate if PPM or CRT/ICD device in situ: _____

If device in situ, date of implantation: _____

PREVIOUS MEDICAL HISTORY:

Please provide details

Previous MI	
Prev CABG	
Other co-existing valve disease	
Prev valve repair or replacement	
Diabetes	
Peripheral Vascular Disease	
Pulmonary Disease FEV1/FVC, DLCO if available	
Smoker	
Currently on dialysis	

THE RBHT MITRACLIP CtE REFERRAL FORM

Please refer to Prof Carlo Di Mario / Dr Rob Smith

**email to Michele Moore, m.moore2@rbht.nhs.uk or Leah Martin L.martin2@rbht.nhs.uk
or phone 01895 828990 / fax 01895 826581**

Cerebrovascular disease	
Other relevant co-morbid condition	

Baseline Investigations

Creatinine	
eGFR	
Hb	
Platelets	
Albumin	
Bilirubin	
INR	
BNP	
ECG: incl QRS duration	

Imaging required: TTE – please send via Medcon or IEP

Please indicate if additional echo/cath data have been provided:

If suitable for assessment, a MitraClip 3D TOE according to a pre-defined protocol will be performed at RBHT.

Please defer TOE assessment locally.

Completed by:

Date:

Contact details - email and phone:

Thank you for the referral