THE UHB MITRACLIP CtE REFERRAL FORM
Please refer to Mr Franco Ciulli / Dr Mark Turner
email to Sandra.schneider@UHBristol.nhs.uk, telephone 01173 426661

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

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)

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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	

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 UHB.
Please defer TOE assessment locally.

Completed by:
Date:
Contact details - email and phone:

Thank you for the referral