THE UHSM MITRACLIP CtE REFERRAL FORM

Please email Anna.Olliviera@uhsm.nhs.uk or fax "The UHSM MITRACLIP team" at 0161 291 2050

Please arrange transfer of all echo and angio images via Medcon or IEP to UHSM (contact for Medcon/IEP, Julie Brodigan at 0161 291 2948)

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? Yes / No

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Current NYHA class	
Current Angina CCS	
Height (cm)	
Weight (kg)	
Body Surface Area	
Body Mass Index	
Major Frailty/Mobility issues	

Current medication:

Class of drug	Drug name	Drug dosage
Diuretics		
ACEi/ARB		
Beta-blocker		
Aldosterone antagonist		
Other		

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

- If device in situ, date of implantation: DD/MM/YYYY

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 If yes, please provide FEV1/FVC, DLCO	
Smoker	
Currently on dialysis	
Cerebrovascular disease	
Other relevant co-morbid condition or past medical history	

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Baseline Investigations

Creatinine	
eGFR	
Hb	
Platelets	
Albumin	
Bilirubin	
INR	
BNP	
ECG (rhythm, QRS duration)	

Additional clinical details:

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Imaging data

- TTE – please send via Medcon or IEP

- Please indicate if additional echo/cath data have been provided: Yes / No

  If Yes, please specify:

- If suitable for assessment, a MitraClip 3D TOE according to a pre-defined protocol will be performed at UHSM.
  Please defer TOE assessment locally, if not already undertaken.

Completed by: _____

Date: DD/MM/YYYY

Contact details

- **e-mail:** _____
- **Phone number:** _____

Thank you for the referral