St James's Hospital Inpatient TAVI Referral Pathway:

Please email referral letter ***and*** completed form to tavi@stjames.ie.

Any incomplete referral forms will be returned.

Cardiologists: Dr Stephen O'Connor

Dr Mark Hensey

Point of contact: Aine O'Connor, Structural Heart Disease Candidate ANP.

Phone: 01 415 1320 **Bleep:** 630

All referrals must include (Please tick):

- Up to date Echo report: ☐
- Up to date ECG: ☐
- Recent blood results including FBC, U&E and NT pro-BNP: ☐
- Contact mobile phone numbers for referring team to discuss referral. ***(Bleep not accepted):*** _____
- Up to date MMSE/MOCA if there is a history of cognitive impairment: ☐

If Echo images not on NIMIS or Universal viewer (Waterford & Kilkenny) – CD to be posted or couriered to:

Aine O'Connor,

Structural Heart Disease cANP,

1st Floor CRU,

St James's Hospital.

On Day of Procedure:

- Arrange transfer to SJH Cath Lab for 8am.
- Fast from midnight, continue clear oral fluids.
- Send copies of recent bloods (FBC, renal, liver and coag), drug kardex, medical and nursing transfer letter and ECG.
- 2 x IV cannulas to be sited (20G minimum, avoid wrists and hands)
- Hold NOAC 48 hrs pre procedure.
- Hold LMWH 24 hrs pre procedure.
- Hold SGLT2 inhibitors 48 hrs pre procedure.

Referral Form:

Patient Details

Name: _____

Age: _____

Date of Birth: _____

Contact Number_____

MRN: _____

Ward: _____

Allergies: _____

Any known Transmissible Infections?

MRSA ☐ VRE ☐ CPE ☐ Other ☐

Details:

_____

_____

On Antiplatelet? Yes ☐ No ☐

On NOAC? Yes ☐ No ☐

NOK Details:

Name: _____

Relationship to Patient: _____

Contact Number: _____

GP Details:

Name: _____

Address: _____

Reason for referral:

_____

_____

_____

_____

Dyspnoea? Yes ☐ No ☐ **NYHA Class: _____**

Chest Pain? Yes ☐ No ☐

Decompensated Heart Failure? Yes ☐ No ☐

IV Diuretics? Yes ☐ No ☐ **NT Pro-BNP: _____**

Syncope? Yes ☐ No ☐

Past Medical History:

_____

_____

_____

_____

Social History:

_____
_____
_____
_____

Current Medications (Include dose and frequency):

Investigations to Date (Attach Reports):

Echo: Yes ☐ No ☐ Date: _____

On NIMIS: ☐ ***On Universal Viewer:*** ☐ ***CD posted:*** Yes ☐ No ☐ N/A ☐

ECG: Yes ☐ No ☐ Date: _____

Coronary Angiogram: Yes ☐ No ☐ Date: _____

CT TAVI: Yes ☐ No ☐ Date: _____

Functional Status:

Independent: Yes ☐ No ☐

Uses walking aid: Stick ☐ Frame ☐ Wheelchair ☐

Assistance x 1: Yes ☐ No ☐

Assistance x 2: Yes ☐ No ☐

Fully Dependent: Yes ☐ No ☐

Cognitive Impairment:

Yes ☐ No ☐

If yes:

MMSE: /30

Or

MOCA: /30 ***Send copy of assessment form.***

Dental Assessment:

Dentition: Good ☐ Poor ☐ Edentulous ☐

Has patient seen a dentist in last 12 months? Yes ☐ No ☐ Date: _____

Are there any current dental concerns? Yes ☐ No ☐

Details:

_____

_____

Send copy of dental cert if completed.

Referrer Details:

Name: _____ Responsible Consultant: _____

Signed: _____ Date: _____

Position: _____

Contact Phone Number (Bleep not accepted): _____

Incomplete Forms will be returned.