McLaren

BAY HEART & VASCULAR

**TAVR Intake Form/Outpatient Order**

Patient Name: _____ DOB: _____ Age: _____

Insurance: _____ Referring Provider: _____/PCP: _____

Date: _____ Reason for Today's Visit: _____

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Coronary Risk: | HTN | Y/N | DM | Y/N | Dyslipidema | Y/N | |
| | Obesity | Y/N | Smoker | Y/N | Family Hx | Y/N | |
| | Last LDL _____ | | Date _____ | | | | |
| Chest Discomfort | Y/N | Palpitations | Y/N | Alert/Oriented | Y/N | Change/Vision | Y/N |
| Dyspnea | Y/N | Claudication | Y/N | Mood/Affect | norm/abnormal | Change/Hearing | Y/N |
| Edema | Y/N | Fatigue | Y/N | Hygiene | G/F/P | G.I. C/O | Y/N |
| Lightheaded, Dizzy | Y/N | | | Ambulatory | Y/N | GU C/O | Y/N |
| Syncope | Y/N | Other: _____ | | | | | |

Pulse _____ BP: Rt. _____ Lt: _____ Orthostatic _____ R ____ Wt. ____ (+/-) Ht. ____ BMI ____

$O_2$ Sat _____ EKG _____ 5 meter walk _____ Questionnaire _____

Nutritional Counseling offered? Y/N Are you in Pain Y/N Location: _____ Pain Scale 0-10: ___

Able to perform ADL's? Y/N Are you being abused or neglected Y/N

PROVIDER NOTED/HPHYSICAL EXAM: _____

_____

_____

_____

Follow-up testing/Lab work: _____

_____

_____

_____

Patient Understanding ☐

**Level of Care:** **E** **C** **New Pt.** **1** **2** **3** **4** **5**

_____ _____

Nursing Date / Time Physician Date / Time

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_____ _____

Nursing Date / Time Physician Date / Time

B-83 (5.20)