Important Videos to Watch

1) Heart Transplantation Video

https://ourhearthub.ca/treatments/

2) LVAD Video

http://pie.med.utoronto.ca/PatientTeaching/projects/left-ventricular-assist-devices/

Your Family Doctor and Dentist

Please be aware we will be communicating with your primary care provider (your family doctor or nurse practitioner). A letter will be forwarded to their office to inform them that you are currently under assessment for advanced heart failure therapies. You have not seen your family doctor in the last year, an appointment will be requested by our office.

It is important that you maintain **good oral health**. This helps to prevent heart infections and to make sure that you do not have any active infections in your mouth before we consider you for surgery.

A letter from our pre-transplant office will also be forwarded to the dentist, whose contact information you have given us. If you have not seen your dentist in the last year, an appointment will be requested by our office.

ASSESSMENT FORMS

The following forms **must be completed and returned to our offices** by e-mail, mail or fax.

1. Patient Information Sheet

2. Patient Consent for E-Mail Communications
    - If you want to communicate with us using e-mail, you must sign this form.

3. Authorization for Disclosure of Personal Health Information
    - Please print your name, sign and date at the space provided.

4. A copy of your Health Card

5. A copy of your COVID 19 Vaccine Confirmation

PATIENT INFORMATION SHEET

Please complete this form and return to the **Heart Transplant Assessment** office.

About You

Name (exactly as appears on your health card):_____

Known allergies: _____

Home Address: _____

Phone Home: _____

Cell: _____

Work: _____

Do you have drug coverage? (Please specify the percentage of your coverage if you know):_____

_____

Are you currently working? (If yes, where do you work and what is your job position?):

_____

Do you currently smoke? (Yes / No)

Do you drink Alcohol? (Yes / No) if you answer yes please specify how much and how often you drink (how many times per day/week or month)_____

_____

Do you use any recreational drug? (Yes / No)

Your Emergency Contact

Name: _____ Phone:_____

Relationship to you: _____

Your Support Person(s)

It is important that your support person is available to attend your transplant apointments with you.

1. Name: _____ Phone: _____

Relationship to you: _____

2. Name: _____ Phone: _____

Relationship to you: _____

Your Health Care Team

Primary Care Provider (your family doctor or nurse practitioner):

Name: _____ Phone: _____

Dentist

Name: _____ Phone: _____

Other Health Care Providers You See (for example, cardiologists or psychiatrists)

1. Name: _____ Phone: _____

Why you see them: _____

2. Name: _____ Phone: _____

Why you see them: _____

3. Name: _____ Phone: _____

Why you see them: _____

Your Current Medications

Medication Name	Dose