CAPITAL DISTRICT PEDIATRIC CARDIOLOGY ASSOCIATES, P.C.

PATIENT REGISTRATION FORM FOR PFO CLOSURE

PLEASE PRINT ALL INFORMATION CLEARLY AND NEATLY

PATIENT NAME:

PATIENT DATE OF BIRTH:

1) PRIMARY CARE PHYSICIAN: NAME AND ADDRESS:

2) CARDIOLOGIST: NAME AND ADDRESS:

3) NEUROLOGIST: NAME AND ADDRESS:

4) OTHER SPECIALISTS INVOLVED IN YOUR CARE: NAMES AND ADDRESSES:

TRANS-ESOPHAGEAL ECHOCARDIOGRAM (TEE): DONE? WHEN? WHERE?

IT WOULD BE MOST HELPFUL TO HAVE COPIES (IF AND WHEN APPLICABLE) OF OFFICE LETTERS FROM YOUR CARDIOLOGIST AND NEUROLOGIST, DISCHARGE SUMMARIES FROM THE HOSPITAL, COPIES OF REPORTS OF THE TESTS YOU HAVE HAD, AND IT IS ESSENTIAL TO HAVE AN ACTUAL CD COPY (NOT JUST A REPORT) OF THE TRANS-ESOPHAGEAL ECHOCARDIOGRAM (TEE) YOU MAY HAVE HAD.

THE MORE INFORMATION PROVIDED, THE BETTER THE ASSESSMENT OF YOUR CONDITION AND THE IMPORTANCE OF THE PATENT FORAMEN OVALE (PFO).