ADVANCED HEART FAILURE/HEART TRANSPLANT REFERRAL FORM

Thank you for your interest in the UAB Transplant Program. Your completion of all the fields below and attachment of medical records will ensure that there are no unnecessary delays in the evaluation of your patient.

Specific Reason for Referral: _____

PLEASE INCLUDE THE FOLLOWING:

- ☐ Patient Demographics
- ☐ Copy of front/back of insurance cards
- ☐ Physical address for packages, if patient has P.O. Box
- ☐ Any cardiac/pulmonary testing
  (echo, heart catheterization, pulmonary function testing)
- ☐ Most recent clinic note

Patient Name: _____

DOB: _____ Marital Status: S M D W

SSN: _____

Race: _____ Ethnicity: _____

Referring MD: _____

Phone: _____ Fax: _____

Any additional information: _____

_____

PLEASE MAIL OR FAX THIS INFORMATION TO:

UAB Advanced Heart Failure and Transplant Office
1900 University Boulevard • THT 311 • Birmingham, AL 35233
(205) 934-3438 • (205) 975-9320 Fax

Patients will be contacted by phone to notify them of the appointment details. Please notify us of any changes in patient's condition or contact information.