LUNG TRANSPLANT REFERRAL FORM

☐ **PLEASE CHECK FOR URGENT REVIEW.**
If your referral requires immediate attention, or hospital to hospital transfer, please call the UAB MIST operator at (800) 822-6478 or (205) 934-6478 and ask to speak with the transplant physician on call.

PATIENT DEMOGRAPHIC INFORMATION

Date: _____

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Gender: M F Race: _____ Ethnicity: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

REFERRING PHYSICIAN INFORMATION

Name: _____ Group Name (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Fax: _____

Person Completing This Form: _____

PATIENT INSURANCE INFORMATION: (please attach a copy of both sides of card)

Insurance Name: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Insurance Phone: _____

Policy Number: _____ Group Number: _____

SECONDARY INSURANCE INFORMATION: (please attach a copy of both sides of card)

Insurance Name: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Insurance phone: _____

Policy Number: _____ Group Number: _____

PATIENT CLINICAL INFORMATION:

Patient Pulmonary Diagnosis: _____ Patient Height: _____ Patient Weight: _____

Smoking Cessation Date: _____ Oxygen use at rest: _____ with Exertion: _____

REQUIRED MEDICAL INFORMATION/DOCUMENTATION: (to best expedite your referral request, please include the following documentation with your referral)

- Recent clinic note
- Current list of medications
- Pulmonary function testing (PFT)
- Most recent lab results
- Recent CXR, CT reports (mail disk to CTC office)
- Reports of any cardiology studies including left and right heart catheterizations, ECHOs, and stress tests (mail images on disk to Cardiothoracic Transplant Office)
- Thoracic Operative Notes

PLEASE FAX COMPLETED FORM WITH DOCUMENTATION TO CARDIOTHORACIC TRANSPLANT OFFICE AT 205.975.9792

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