Lung Transplant Program Referral Form
9500 Euclid Avenue A100, Cleveland, Ohio 44195
Telephone (216) 444-8282 Fax (800) 878-9389

Only complete referrals will be considered.

Please attach pertinent forms or complete sections below and fax to **800-878-9389**. Please allow 2-3 business days for patients to be contacted.

In order to expedite process please attach the following demographic information:

- Patient demographics form (or complete section A below)
- Copy of primary and secondary insurance card (or complete section B below)
- Copy of contact information for Referring and Primary Physician (or complete section C below)

For Transplant consideration we must receive:

- Pertinent Cardiology & Radiologic studies including: Left Heart Cath, Echo, Stress Test, CT & Chest X-Ray
  - Send images to address above
- Last 12 months results for arterial blood gas and pulmonary function test
- Hospital Discharge Summaries for last two years (if any)
- History & Physical and pertinent clinical notes
- Previous transplant evaluation reports, including Social Work notes
- Previous transplant centers acceptance or declination letters

A. Patient Information:

Name: ____________________
Address: ____________________
City: ____________________
State: ____________________
Zip: ____________________
Home/Cell: ____________________
E-Mail: ____________________

DOB: ____________________
SSN: ____________________
Marital Status: ____________________
Gender: ____________________
Race: ____________________
Ethnicity: ____________________
Employed____ Unemployed____ Retired____ Disabled___

Emergency Contact: ____________________ Phone: ____________________ Relationship__________

B. Primary Insurance

Primary Insurance: ____________________
Policyholder's Name: ____________________
Policyholder's DOB: ____________________
Policy ID: ____________________
Group Number: ____________________
Policy Holder's DOB: ____________________
Policy Holder's SSN: ____________________

Secondary Insurance:

Primary Insurance: ____________________
Policyholder's Name: ____________________
Policyholder's DOB: ____________________
Policy ID: ____________________
Group Number: ____________________
Policy Holder's DOB: ____________________
Policy Holders SSN: ____________________

C. Referring Physician Information

Name: ____________________
Practice Name: ____________________
Address: ____________________
City: ____________________
State: __________ Zip: __________
Office Phone __________ Fax: __________

Primary Care Physician Information

Name: ____________________
Practice Name: ____________________
Address: ____________________
City: ____________________
State: __________ Zip: __________
Office Phone __________ Fax: __________