

MEDICAL CENTER

Lung Transplant Program
1313 21st Avenue South
1105 Oxford House
Nashville, TN 37232-4760
Phone: 615.936.0393 Fax: 615.936.0396

REFERRAL FOR LUNG TRANSPLANT EVALUATION

Date: _____

Patient would like to be seen in the Madison, Alabama Outreach Clinic?

Thank you for your referral. The following information will help assist us in scheduling your patient as soon as possible.

PATIENT'S NAME: _____ DOB: _____ SSN: _____

Pulmonary Diagnosis: _____

O2 REQUIREMENTS: _____ L at rest _____ L with exertion

Please attach the following items to this referral, if available:

- Patient Demographics Sheet**, including DOB and SSN
- Copy of insurance cards** front and back
- Most recent clinic note** including history & physical, BMI, medication list
- Discharge summaries** from any hospitalizations within the last six months
- Diagnosis and Treatment Notes involving any history of malignancy
- Most recent laboratory reports** (i.e., CBC, CMP, PT/INR, Urine cotinine/nicotine testing, and positive sputum cultures)
- Most recent radiologic studies:** Chest XRay, Chest CT and VQ Scan if available. Please also send disks to address above.
- Most recent PFT, ABG, and Six Minute Walk**
- Lung Biopsy reports if applicable
- Most recent Echocardiogram and Cardiac Cath
- Most recent endoscopy and colonoscopy

REFERRING PROVIDER: _____ PRACTICE NAME: _____

Provider Phone: _____ Provider Fax: _____

Please FAX completed forms and available documents to 615.936.0396
ATTN: Pre-Transplant Coordinator

Patient referral is also available online at www.vanderbilthealth.com/transplant.