VANDERBILT UNIVERSITY

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: _____

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: _____ LPM at rest _____ LPM 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 http://www.vanderbilthealth.com/transplant.