UPMC | TRANSPLANT SERVICES

Referral Form:
UPMC Lung Transplant Program

Please complete ALL FIELDS of this form to expedite processing and fax to 412-864-5913. Once we have received the completed forms and records, patient will go through financial clearance, interview, and be scheduled for evaluation if the program director determines the patient is a lung transplant candidate. This process may take approximately 2-4 weeks.

Patient Information

Name: _____

Address: _____

_____

DOB: _____ Gender: ☐ Male ☐ Female

Race/Ethnicity: _____

SSN: _____
(referral cannot be processed without SSN)

Check one:

☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

If employed, name and address of employer:

_____

Home phone: _____

Cell phone: _____

E-mail: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Height: _____ Weight:

Smoking cessation data, if applicable: _____
(4 months nicotine abstinence required)

Emergency contact /relationship: _____

Phone: _____

Patient diagnosis: _____

_____

PLEASE ATTACH:

- Results of most recent (within one year) tests for pulmonary function and arterial blood gases
- Results of most recent cardiac cath, stress test, and/or echocardiogram (for patients with history of cardiac disease)
- Most recent history, physical results, and/or discharge summary
- Most recent CT scan
- Results of previous transplant evaluations, if available

Referring Physician Information

Name: _____

Address: _____

Phone: _____ Fax: _____

Office contact/name _____

Primary Care Physician Information

Name: _____

Address: _____

Phone: _____ Fax: _____

Insurance Information

Complete ALL FIELDS as fax copies of insurance cards may be illegible
(fax FRONT AND BACK copy of patient's insurance card)

Primary insurance name: _____

Phone: _____

If Medicare, effective after date: _____

Policy #: _____ Group #: _____

Policy holder's name: _____

If not self, provide policy holder's

Name: _____

DOB: _____

SSN: _____

Policy holder's employer: _____

Policy holder employer address:

_____

Secondary insurance: _____

Phone: _____

Policy #: _____ Group#: _____

CONTACT US:
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EMAIL: cttransplant@upmc.edu