



Lung Transplant Referral Form

Any Questions?
Feel free to contact us.
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Patient Information

Name: _____
Diagnosis: _____ Reason for Referral: ☐ Transplant ☐ Second Opinion
Emergency Contact: _____ Relationship: _____
DOB: _____ Gender: _____ SSN (required): _____
Address: _____
Cell Phone: _____

Please attach the following records, if available:

Pulmonary Function Tests
Referring providers' notes
Any cardiac testing available (Heart catheterization, ECHO)
Chest Imaging (X-ray and CT scan reports)

Insurance Information

Primary Insurance name and phone: _____ (please include copy of insurance card, if available)
Policy Holder (Name): _____ Policy #: _____ Group #: _____

Referring Provider

Name: _____
Practice/Address: _____

Phone: _____
Fax: _____

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