

Fax to: TXP Referral Coordinator

(Please Print)

Fax #: 434-924-8774

Heart Only LVAD and Heart LVAD Only

Today's date:		Name of Practice:					
Address:			Phone: ()		Fax: ()		
Referring Provider:			Contact Person:				
PCP (if different from referring):							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date / /	Soc. Security Number - - - - -	
Street address:			PO Box:		Home phone: ()		
City:	State:	ZIP Code:	Work phone: ()		Cell phone: ()		
Name Additional Contact:		Relation to Patient:		Primary phone: ()		Cell phone: ()	
Preferred language: Interpreter needed: <input type="checkbox"/> Y <input type="checkbox"/> N					Marital Status:		
INSURANCE INFORMATION							
(Please Include Copy of Insurance Card)							
Is this patient covered by insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Please indicate primary Insurance:							
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /	Group no.:	Policy no.:	
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
PLEASE INCLUDE THE FOLLOWING AVAILABLE RECORDS							
<input type="checkbox"/> Recent History & Physical <input type="checkbox"/> 3 Months Clinic Notes <input type="checkbox"/> CXR Results <input type="checkbox"/> All Path Reports <input type="checkbox"/> Immunizations		<input type="checkbox"/> Cardiac Cath <input type="checkbox"/> Echo <input type="checkbox"/> EKG <input type="checkbox"/> CT Chest/ABD/Pelvis <input type="checkbox"/> PFTS/6 minute walk <input type="checkbox"/> Any cardiac surgeries OP notes		<input type="checkbox"/> Perfusion Scans <input type="checkbox"/> Peripheral vascular studies <input type="checkbox"/> Carotid US studies <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Mammogram (female) <input type="checkbox"/> Pap Smear (female)		Most Recent Lab Results <input type="checkbox"/> Chemistries <input type="checkbox"/> Hematology <input type="checkbox"/> ABO/Blood Type <input type="checkbox"/> 24 hour Urine/Creatinine Clearance <input type="checkbox"/> PSA (males)	

PO Box 800265, Charlottesville, VA 22908

Phone: 434-924-8604 or 1-800-257-0757