UVAHealth

Charles O. Strickler Transplant Center
Lung Transplant Referral Form

Fax to: TXP Referral Coordinator **Fax #: 434-924-8774**

(Please Print)

❑ **Lung Only** ❑ **Lung and Heart** ❑ **Consult Only** ❑ **Other Eval/Procedure** _____

Today's date:	Name of Practice:		
Address:		Phone: ( )	Fax: ( )
Referring Provider:		**Contact Person:**	
Preferred way to contact: Fax___ Phone ___ Email: _____			Do you use Epic Yes ___ No ___
PCP (if different from referring):			

PATIENT INFORMATION

Patient's last name: First:		Middle:	Sex ❑ M ❑ 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: ❑ Y ❑ N					Marital Status:

INSURANCE INFORMATION

(Please Include Copy of Insurance Card)

Is this patient covered by insurance?	❑ Yes	❑ 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.:	

LUNG DIAGNOSIS INFORMATION

(Please Check All That Apply)

❑ COPD ❑ CF ❑ IPF ❑ ILD ❑ Sarcoidosis ❑ Other _____

PLEASE INCLUDE THE FOLLOWING AVAILABLE RECORDS

❑ 3 Months Clinic Notes	❑ Cardiac Cath
❑ CXR Results	❑ EKG/ECHO
❑ All Path Reports	❑ Chest CT
❑ Immunizations	❑ PFTs/6 minute walk
	❑ ABO/Blood Type

PO Box 800265, Charlottesville, VA 22908 **Phone: 434-924-8604 or 1-800-257-0757**

For UVA Transplant Staff Only

Date Received: _____ **Received By:** _____