Complete and print.

Reset Form

MAYO CLINIC

Heart Transplant Referral Program

Form content retained in medical record.
Route to HIMS Scanning.

TO BE SCANNED

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*	
Birth Date *(mm-dd-yyyy)*	Room Number (if applicable)
Mayo Clinic Number	

Instructions: Fax the most recent history and physical, list of current medications, most recent heart cath, echocardiogram, chest x-ray, and labs, if available, along with the completed form to 480-342-3786. For questions, call 480-342-1010.

Referring Provider Information

Referring Provider Name *(First, Middle, Last)*		Date *(mm-dd-yyyy)*
Office Address *(Street, City, State, ZIP Code)*		
UPIN Number	Phone	Reply to Fax
Contact Person Name *(First, Middle, Last)*		

Patient Information

Sex Assigned at Birth
☐ Male ☐ Female ☐ Choose not to disclose

Address *(Street, City, State, ZIP Code)*			
County	Home Phone	Work Phone	Cell Phone
Other Contacts			

Insurance Number 1	Policy Number	ID Number	Subscriber	Benefit Contact
Insurance Number 2	Policy Number	ID Number	Subscriber	Benefit Contact

Medical Information

Diagnosis						
Medical Problems						
Stroke ☐ Yes ☐ No	PVD ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Renal Disease ☐ Yes ☐ No	Hepatic Disease ☐ Yes ☐ No	Pulmonary Disease ☐ Yes ☐ No	Malignancy ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No	Smoking History ☐ Yes ☐ No	ETOH History ☐ Yes ☐ No	Substance History ☐ Yes ☐ No	Pregnancy No.___ ☐ Yes ☐ No	Height *(cm)*	Weight *(kg)*
Comments						

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