MAYO CLINIC

Referring a Patient to: Heart Transplant Program at Mayo Clinic

Complete, print and submit.

Please fax this form to: (480) 342-3646
For questions, please call: (480) 342-1010
Thank you for referring your patient to Mayo Clinic.

Reset Form

Referring Physician Information

Referring Physician's Name			Date *(mm-dd-yyyy)*
Office Address			UPIN No.
City	State	Zip Code	Phone
Reply to Fax No.	Contact Person		

Patient Information

Patient Name *(First, Middle, Last)*			Sex	SSN
Address			County	
City	State	Zip Code	Date of Birth *(mm-dd-yyyy)*	
Home Phone	Work Phone		Cell Phone	
Other Contacts				
Insurance No. 1	Policy No.	ID No.	Subscriber	Benefit Contact
Insurance No. 2	Policy No.	ID No.	Subscriber	Benefit Contact

Medical Information

Diagnosis

Please fax the following information: Most recent history and physical; list of current medications; most recent heart cath, echocardiogram, chest x-ray, and labs, if available.

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 #____ ☐ Yes ☐ No	**Height** _____	**Weight** _____

Print