Referring a Patient to: Lung Transplant

Please fax this form to: 480-342-4513
For questions, please call: 480-342-1010
Thank you for referring your patient to Mayo Clinic.

Referring Physician Information **PCP:** ____________________

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

Patient Information

Patient Name *First* *Middle Initial* *Last*			Sex	SSN
Address			County	
City	State	Zip	Date of Birth *(mm/dd/yyyy)*	
Home Telephone	Work Telephone		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: current history and physical (including height and weight), complete list of current medications, most recent PFTs, R heart catheterization (if available), written report & disc of any recent radiological testing (CT scan, MRI, CXR, etc), surgical report if open heart surgery, copy of insurance card, and demographics sheet.

Medical Problems

Stroke	PVD	Diabetes Type 1 or 2	Renal Disease	Hepatic Disease	Heart Disease/Stents/ Surgeries	Malignancy
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Osteoporosis	Smoking History	ETOH History	Substance History	Pregnancy #_____	**Height**	**Weight**
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	____________	____________

Previous transplants? ☐Yes ☐No	Previous lung transplant evaluation? ☐Yes ☐No	
Oxygen Amount? Continuous? ☐Yes ☐No	Prednisone use? ☐Yes ☐No If yes, amount?	Previous Prednisone use? ☐Yes ☐No If yes, amount?
Last PFT?	Last CT Chest Scan? (must have CD with films before visit)	

©2016 Mayo Foundation for Medical Education and Research