Lung Transplant Physician Referral Form

Inpatient transfer request? ◯ Yes ◯ No If urgent consultation is needed, please call **614-293-4444**.

To speak with a lung transplant coordinator, call **866-204-3411**.

Please fill out this form completely, include any clinical documentation relevant to this referral, and fax all documents to **614-293-9820**.

Mail any additional imaging CDs and/or documentation to: **410 W. 10th Ave., 825 Doan Hall, Columbus, OH 43210**.

◯ **Clinical Documentation included**
Please provide patient demographics, insurance, office notes, office procedures, imaging, lab work, etc.

Patient Information:

First Name: | **Middle Name:** | **Last Name:**

Gender: | **Marital Status:** | **Last 4-digits SSN#:** | **Date of Birth (mm/dd/yyyy):** | **BMI:**

Primary Phone: | **Email:** | **Primary Insurance:** | **Secondary Insurance:**

Street Address:

City: | **State:** | **Zip:** | **County:**

Details:

Reason for Referral:

Preferred Physician or Provider Name if Applicable:

Department or Specialty Area:

◯ Consult or Second Opinion ◯ Transfer of Care

Referring Provider Information:

Provider First Name: | **Provider Last Name:**

Provider Title: | **NPI Number:** | **If referring provider would like to attend virtual candidacy discussion, please provide email:**

Street Address: | **City:** | **State:**

Zip: | **Phone:** | **Extension:** | **Fax:**

Physician Signature:_____ Date:_____