

# Lung Transplant Physician Referral Form

**Inpatient transfer request?** Yes  No

If urgent consultation is needed, please call **614-293-4444**.

Updated 4/16/2026

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**.

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

**Clinical Documentation:** 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:  Country:

## Details:

Reasons for Referral:  Preferred Physician or Provider:   
Department or Specialty Area:

## 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: \_\_\_\_\_