



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: _____