

Lung Program Referral FAX and Cover Sheet/Checklist

Please fill out form completely and send medical records by FAX to the AdventHealth Transplant Institute.

DATE: _____

To: Transplant Institute Intake Coordinator _____

FAX: 407-303-0894 _____

FROM: _____

Practice Name: _____

Referring Physician: _____

Contact: _____

Phone #: _____

Address: _____

FAX #: _____

PATIENT INFORMATION

Name: _____

Reason for Referral/DX#: _____

DOB: _____

SS#: _____

Please include the following items with the patient referral:

- | | |
|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Demographics and insurance information | <input type="checkbox"/> Recent 6MW/oxygen titration study |
| <input type="checkbox"/> H&P/progress notes within the last year | <input type="checkbox"/> Recent HLA/PRA testing (if applicable) |
| <input type="checkbox"/> Recent chest X-ray and CT chest (reports and imaging) | <input type="checkbox"/> Recent labs done within the last 6 months to include CBC, CMP and any other disease-specific testing if done |
| <input type="checkbox"/> Sputum cultures with susceptibilities, all done within the last 2 years | <input type="checkbox"/> Heart cath and echo (reports and imaging) |
| <input type="checkbox"/> PFTs done within the last 2 years | <input type="checkbox"/> Any other pertinent information is appreciated |
| <input type="checkbox"/> ABG/VBGs done within the last year | |

If any medical record is available, please indicate on this form.

Mail imaging CDs to: AdventHealth Transplant Institute, Attention Lung Transplant Program, 2415 North Orange Avenue, Suite 700, Orlando, FL 32804

Confidentiality Notice

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