UPMC | TRANSPLANT SERVICES

REFERRAL FORM:
UPMC Heart Transplant Program

Please complete ALL FIELDS of this form to expedite processing and fax or efax to **412-864-5913**. Once we have received the completed forms and records, patient will go through financial clearance, interview, and be scheduled for evaluation if the program director determines the patient is a heart transplant candidate. This process may take approximately 2-4 weeks.

Patient Information

Name: _____

Address: _____

_____

DOB: _____ Gender: ☐ Male ☐ Female

Race/Ethnicity: _____

SSN: _____
(referral cannot be processed without SSN)

Check one:

☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

If employed, name and address of employer:

_____

Home phone: _____

Cell phone: _____

Email: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Height: _____ Weight: _____

Smoking cessation data, if applicable: _____
(4 months nicotine abstinence required)

Emergency contact /relationship: _____

Phone: _____

Patient diagnosis: _____

_____

PLEASE ATTACH:

- Results of your most recent cardiac cath, echocardiogram, stress test, EKG, CT chest scan, vascular studies, chest-x-ray, pulmonary function test, and abdominal ultrasound
- Most recent history & physical results, progress notes, and discharge summary
- Results of previous transplant evaluations, if available

Referring Physician Information

The Below Fields Are Mandatory.

Please complete the below information in its entirety. Our team will need to contact you at various stages throughout the referral, evaluation, and transplant process.

Name: _____

Address: _____

Office phone: _____

Email address: _____

Cell phone: _____ Fax: _____

Office contact/name _____

Insurance Information

Complete ALL FIELDS as fax copies of insurance cards may be illegible
(fax FRONT AND BACK copy of patient's insurance card)

Primary insurance name: _____

Phone: _____

If Medicare, effective after date: _____

Policy #: _____ Group #: _____

Policy holder's name: _____

If not self, provide policy holder's

Name: _____

DOB: _____

SSN: _____

Policy holder's employer: _____

Policy holder employer address: _____

_____

Secondary insurance: _____

Phone: _____

Policy #: _____ Group #: _____

CONTACT US:

Phone: 412-648-6202 OR Toll Free: 844-548-4591
Email: cttransplant@upmc.edu