UPMC | TRANSPLANT SERVICES

REFERRAL FORM:
UPMC Lung 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 lung transplant candidate. This process may take approximately 2-4 weeks.

Patient Information

Name: ______________________________

Address: ______________________________

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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:

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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: ______________________________

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PLEASE ATTACH:

- Results of most recent (within one year) tests for pulmonary function and arterial blood gases
- Results of most recent cardiac cath, stress test, and/or echocardiogram (for patients with history of cardiac disease)
- Most recent history, physical results, and/or discharge summary
- Most recent CT scan
- 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: ______________________________

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Secondary insurance: ______________________________

Phone: ______________________________

Policy #: ______________ Group #: ______________

CONTACT US:

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

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