Cleveland Clinic

Lung Transplant Program Referral Form

9500 Euclid Avenue A120 Cleveland, Ohio 44195
Telephone (216) 444-8282 Fax (216) 445-3127

Please attach pertinent forms or complete sections below and fax to **216-445-3127**. Please allow 2-3 business days for patients to be contacted.

In order to expedite process, please attached the following demographic information:

- Patient demographics form (or complete section A below)
- Copy of primary and secondary insurance card (or complete section B below)
- Copy of contact information for referring and primary physician (or complete section C below)
- Please include information if related to workman's compensation

For Transplant consideration we must receive:

- Pertinent cardiology & radiologic studies including: Left Heart Cath, Echo, Stress Test, CT & Chest X-Ray
  - Send images to address above
- Last 12 months results for arterial blood gas and pulmonary function test
- Hospital discharge summaries for last two years (if any)
- History & physical and pertinent clinical notes
- Previous transplant evaluation reports, including social work notes
- Previous transplant centers acceptance or declination letters

A. Patient Information:

Name: _____ DOB: _____
Address: _____ SSN#: _____
City: _____ Marital Status: _____
State: _____ Gender: _____
Zip: _____ Race: _____
Home/Cell: _____ Ethnicity: _____
E-Mail: _____ Employed: ___ Unemployed ____ Retired ____ Disabled

Emergency Contact: _____ Phone: _____ Relationship: _____

B. Primary Insurance

Primary Insurance: _____
Policyholder's Name: _____
Policyholder's DOB: _____
Policyholder's SSN: _____
Policy ID: _____
Group Number: _____

Secondary Insurance:

Secondary Insurance: _____
Policyholder's Name: _____
Policyholder's DOB: _____
Policyholder's SSN: _____
Policy ID: _____
Group Number: _____

C. **Referring Physician Information**

Name: _____
Practice Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Office Phone: _____ Fax: _____

Primary Care Physician Information

Name: _____
Practice Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Office Phone: _____ Fax: _____