



LUNG TRANSPLANT REFERRAL FORM

Fax Completed Form with Documents listed below:

Fax 404-712-1273 Phone 855-366-7989, Ext 4

etclungreferral.fax@emoryhealthcare.org

Referral Date _____ Phone _____
Completed By _____ Fax _____
Referring Physician _____ Referring Diagnosis _____
Address _____ City _____ State _____ Zip _____

Patient Name _____ DOB _____ Age _____
Address _____ City _____ State _____ Zip _____
Sex _____ Race _____ Social Security # _____
Phone _____ Alternate # _____

Insurance Company _____ Group Number _____
Insurance Subscriber _____ Policy Number _____
Relationship to Patient _____

Recent Office Notes	☐ Yes ☐ No	Notes _____
Pulmonary Function Testing/Six-Minute Walk	☐ Yes ☐ No	Notes _____
Radiology Reports (Chest CT, Chest X-Ray, etc)	☐ Yes ☐ No	Notes _____
Diagnostic Reports (Pathology, Cardiac Cath, etc)	☐ Yes ☐ No	Notes _____
Copy of Insurance Card (Front & Back)	☐ Yes ☐ No	Notes _____
Copy of Driver's License	☐ Yes ☐ No	Notes _____