EMORY HEALTHCARE

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 ______________