UFHealth
SHANDS TRANSPLANT CENTER

1600 SW Archer Road • P.O. Box 100223 • Gainesville, FL 32610-0223
Direct Office Line: 352.265.8940 • Fax: 352.265.8970 • Fax to PDF: 352.627.4417
UFHealth.org/transplant-center/lung

Lung Transplant Program Appointment Request Form

NOTE: To avoid delay, please fax the following records:

- ☐ Most current History and Physical within the last 12 months.
- ☐ Discharge summary from hospitalizations within the last 12 months.
- ☐ Diagnostic reports PFTs, heart studies (cath, echo, stress), chest X-ray, CT scans, pertinent labs, sputum cultures, operative notes and pathology (lung-related).
- ☐ **Copy of insurance cards (front and back).**
- ☐ Prior to your patient's first appointment with the UF Health Shands Transplant Center's Lung Transplant Program, we will request that you provide the patient's most recent chest CTs and X-rays. **We will be unable to evaluate your patient's candidacy without this imaging.** If you have questions, please contact our office immediately.

Thank you for choosing UF Health Shands Transplant Center Lung Transplant Program. Please complete the information below and mail or fax with requested supporting documentation to 352.265.8970. Your patient will be contacted regarding scheduling of an appointment after the referral is received and reviewed and a letter will be sent to your office. We look forward to meeting your patient and the opportunity to work with you. Please don't hesitate to call our Pre-Transplant Team for any questions.

Date: _____ Name: _____ SSN: _____

Address: _____ City/State/Zip: _____

Telephone: _____ County: _____ DOB: _____

Cell or Alternate #: _____ Email: _____

Diagnosis: ☐ COPD ☐ ILD ☐ CF ☐ Other: _____

Weight: _____ Height: _____ BMI: _____

Smoking History: _____ years x _____ PPD Quit: ☐ Yes ☐ No Date last smoked: _____

O_2 use: _____ LPM @ rest / night / exertion

Referring MD: _____ Group Practice: _____

MD UPIN: _____ NPI#: _____ Medical License #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Contact Person: _____ Number/Ext.: _____

Office Email Address: _____

Insurance Carrier #1: _____ Telephone #: _____

Policy #: _____ Group #: _____

Policyholder: ☐ Patient ☐ Other (Name): _____ ☐ Medicaid ☐ Medicare

Insurance Carrier #2: _____ Telephone #: _____

Policy #: _____ Group #: _____

Policyholder: ☐ Patient ☐ Other (Name): _____ ☐ Medicaid ☐ Medicare

If you have any questions or there is a problem with the transmittal of this fax, please call **352.265.8940** and ask for one of the Transplant Assistants.