University Health

LUNG REFERRAL FORM

PLEASE FILL OUT THE INFORMATION BELOW:

Patient Name:_____

Date of Birth:_____

Social Security Number:_____

Address:_____
(Street)

_____
(City/State/Zip)

Phone Number:_____

Gender: ❑ Male ❑ Female

Language: ❑ English ❑ Spanish ❑ Other:_____

Marital Status:_____

Primary Insurance:_____

Secondary Insurance:_____

Please notify Primary Care Physician (PCP) of this referral if this is mandated by the insurance company.

Referring Physician Information

Name:_____

Address:_____
(Street)

_____
(City/State/Zip)

Phone: _____ Fax: _____

Office Contact:_____

Patient Information

Lung Disease: _____

If patient is a former smoker, how long has he/she been abstinent?_____

Height: _____ Weight: _____

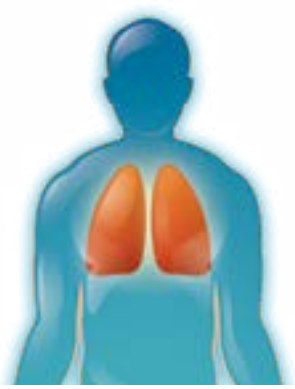
Additional Information:

_____

_____

_____

_____



Date of Referral:

Month	Day	Year

❑ Lung Transplant ❑ Pulmonary Hypertension

❑ Interventional Pulmonology

Please fax the following information with this form if available:

- ❑ Patient's demographic form
- ❑ Copy of insurance cards (front and back)
- ❑ Recent history and physical
- ❑ Most recent labs
- ❑ Immunizations
- ❑ Last three PFT reports
- ❑ Recent CXR reports
- ❑ All Chest CT reports
- ❑ Sputum cultures and sensitivities (if available)
- ❑ Any cardiology testing
- ❑ Lung biopsy pathology report (if available)
- ❑ Hospital discharge summaries (if applicable)

Contact Information:

Referral Hotline
210-743-4263

Referral Fax
210-358-8254

Referral Address
University Transplant Center
4502 Medical Dr., MS 18, San Antonio, TX 78229

UniversityTransplantCenter.com/referral