MUSC Health
Medical University of South Carolina

# Lung Transplant Center Referral Form



Form Origination Date: 1/2020
Version: 1 Version Date: (1/2020)

**Lung Transplant Center**

**Phone: 843-792-5097**
**Fax: 843-792-7845**

FAX TO: 843-792-7845

**If you have any questions in facilitating a referral, please call us at 843-792-5097.**

**Patient Information** Name: _____

Diagnosis: _____ Reason for Referral: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Address: _____

DOB: _____ Gender: _____ Race: _____ SSN (required): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____ Smoking cessation date, if applicable: _____

**Please attach the following records if available:**

- ☐ Pulmonary Function Tests (include up to past 5 years)
- ☐ Referring physician's notes (include up to past 5 years)
- ☐ Cardiac Testing
  - Heart catheterization
  - Stress test
  - ECHO
  - MRI
  - EKG
- ☐ Serum labs within the last year
- ☐ Sputum cultures within the last year
- ☐ Women: PAP smear for age ≥18; Mammogram for age ≥40 of positive history
- ☐ Men: Current PSA age ≥50
- ☐ GI: Endoscopy or Colonoscopy for positive history or age ≥50
- ☐ Chest Imaging (X-ray and CT scan reports)
- ☐ Immunization records
- ☐ DEXA (bone density) scan

**Insurance Information** (please include copy of patient's insurance card)

Primary Insurance name and phone: _____

Policy Holder's Name: _____ Policy #: _____ Group #: _____

**Referring Provider Information** Name: _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

How did you hear about MUSC? _____