Lung Transplant Program
F6511 A UH South
1500 East Medical Center Drive
Ann Arbor, MI 48109-5244
Referral Coordinator: 734-232-8427 Fax: 734-615-1009

REQUEST FOR LUNG TRANSPLANT EVALUATION

PLEASE COMPLETE FORM AND FAX TO 734-615-1009. Missing information may delay the referral process.

Today's Date: _____ **Contact Name & Number:** _____

Section 1: Patient Information

Patient Name: **(PLEASE PRINT)** _____

Address: _____City/State/Zip: _____

Date of Birth: ____/____/____ Sex: Female ☐ Male ☐

Telephone #s: (home): (_____) _____ (cell or work): (_____) _____

Patient's Insurance (REQUIRED): Please include copy of Insurance card or card information.

☐ BCN ☐ BCBS ☐ Medicaid ☐ Medicare ☐ **HMO** ☐ **POS** ☐ **PPO** ☐ Other _____

Id Number:_____ Group Number: _____

Section 2: Physician Information

Referring Physician's Name: _____ UPIN # _____

Address: _____ City/State/Zip: _____

Telephone #:(_____) _____ Fax Number:(_____) _____

Primary Care Physician's Name: _____ UPIN # _____

Address: _____ City/State/Zip: _____

Telephone #:(_____) _____ Fax Number:(_____) _____

Section 3: Patient History

Diagnosis: _____

Reason for referral: _____

To avoid duplication of tests, please list relevant studies and date completed: Fax reports if not performed at U of M

☐ PFT date: ____/____/____ Location: _____

☐ Lung Biopsy date: ____/____/____ Location: _____

☐ Chest X-Ray date: ____/____/____ Location: _____

☐ Chest CT date: ____/____/____ Location: _____

If available, please send digital images to address above.