UCSF Medical Center
Heart & Lung Transplant

UCSF Lung Transplant Request for Consultation

Patient Name: _____

Street Address: _____

City/State/Zip Code: _____

Phone number: _____ **Date of Birth**: _____

Social Security Number: _____-_____-_____ **Gender**: ☐ Male ☐ Female

Height: _____ in___cm___ **Weight**: _____lbs___Kg___

Insurance: _____

Phone number: _____

Insurance ID number: _____

Case Manager: _____

If the patient has insurance which requires a referral or authorization, please include this with any faxed records. Please include a copy of the front and back of the patient's insurance card with your records.

Consulting For:

Diagnosis: _____ **ICD9**: _____

Past Medical History: _____

Referring Physician: _____ **Signature**: _____

Street Address: _____

City/State/Zip Code: _____

Office Phone: _____ **Office FAX**: _____

Primary Care Physician: _____

Street Address: _____

City/State/Zip Code: _____

Office Phone: _____ **Office FAX**: _____

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Smoking History:

Never _____ Former _____ Regular ____

Type and Amount: Cigarettes _____ Number of packs per day _____

Other _____

Age began smoking _____ Age quit _____

Alcohol Use:

Never _____ Former _____ Regular ____ Amount _____

Recreational Drug Use:

Never _____ Former ____ Regular ____

Type _____ Years of use _____

At minimum, we will need the following in order to evaluate whether it is appropriate to see the patient in clinic for evaluation:

____Clinical Summary (comprehensive H&P, thorough office visit note or recent Discharge Summary)

____Pulmonary Function Studies (from within the past 6 months)

____Chest CT (from within the past 6 months)

We encourage you also to include any of the following from your records:

____V/Q scan results
____Lung biopsy reports and slides
____Office visit notes
____Recent labs
____Discharge Summaries
____Echocardiogram results
____Bronchoscopy reports
____Historic CT and PFT reports

Please also include any disease specific information that we might find useful, for example: Cardiac Catheterization report if patient has diagnosis of Coronary Artery Disease, Rheumatology notes and lab tests if Rheumatologic Disease, Cystic Fibrosis testing if CF patient.

Please complete this form as comprehensively as possible and fax it, along with all supporting records, to our office at 415-353-4166. You may follow up with a phone call to ensure that your records have been received if you wish.

Thank you for your assistance.

Jill Obata, RN (A-K)
Lung Transplant Coordinator
415-514-6678 or 415-353-4164

Kerry Kumar, RN (L-Z)
Lung Transplant Coordinator
415-353-9338 or 415-353-4164