Medical University of South Carolina Lung Transplant Program Referral Form

Please print and complete this form in full before faxing it to 843-792-7845. Once we receive it, we will contact your patient to schedule an initial clinic visit, if appropriate. This process generally takes two weeks. If you have any questions in facilitating a referral please call us at 843-792-4773 or 800-277-8687 Option #8.

For Office Use Only
Received : __/__/___

Patient Information

Name: _____

Address: _____

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

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Smoking cessation date, if applicable: _____

Please Attach:

- Pulmonary Function Tests (include up to past 5 years)
- Referring physician's notes (include up to past 5 years)
- Cardiac Evaluation with stress test, MRI, EKG ect. if available
- Serum labs within the last year
- Echo Report
- 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: Colonoscopy for positive history or age ≥ 50
- Chest X-Ray and CT scan either bring hard copy or send
- Immunizations
- Any GI work up: Endoscopies or reflux work up
- DEXA scan

Emerg. Contact: _____ Phone: _____ Relationship: _____

Patient Diagnosis: _____

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

Primary Insurance name and phone: _____

Policy Holder's name: _____

Policy #: _____ Group #: _____

Referring Physician Information

Name: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

How did you hear about MUSC: _____