



**Referral Form for New Heart Transplant Patients**

**Patient's Personal Information**

Patient's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Patient's address: \_\_\_\_\_

Patient's Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Height: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Smoker: Yes, still smoking  Yes, quit smoking  Date Quit: \_\_\_\_\_

No, never smoked  Smokeless tobacco

**Referring Physician's Information**

Physician's Name: \_\_\_\_\_

Physician's address: \_\_\_\_\_

Office #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Insurance Information**

Insurance: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Identification#: \_\_\_\_\_ Group #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Barbara Czerska, MD  
Medical Director Heart Transplant Program  
Florida Hospital  
2415 N. Orange Ave, Suite #600  
Orlando, FL 32804  
Office: 407 303-7171  
Fax: 407 303-7195