



Referral Form for New Lung 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 #: _____

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