



McKelvey Lung Transplantation Center  
Evaluation Referral Form

PLEASE FAX THIS COMPLETED REFERRAL FORM, RECENT H&P/VISIT NOTE, A COPY OF FRONT & BACK OF ALL INSURANCE CARDS, AND A COPY OF THE LONG TERM CARE PLAN TO (404) 727-1516.

Referring Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Referral Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Street Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation to Pt: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**INSURANCE INFORMATION** \*Please include a copy of front/back of insurance card(s).

Medicare: YES  NO

Auth / # of Visits: \_\_\_\_\_

Primary Insurance Company Name: \_\_\_\_\_

Auth / # of Visits: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ UPIN# \_\_\_\_\_

Auth / # of Visits: \_\_\_\_\_

Georgia Medicaid  Georgia Better Healthcare  (Please check if applicable)

**MEDICAL INFORMATION**

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

Pulmonary Function Results: \_\_\_\_\_ Date: \_\_\_\_\_ Supplemental O<sub>2</sub> \_\_\_\_ liters

FEV1 \_\_\_\_\_ VC \_\_\_\_\_ DLCO \_\_\_\_\_

Has patient used tobacco in any form in the past? YES  NO  Is the patient currently smoking? YES  NO

Has the patient had previous chest surgery, pleurodesis or chest tube insertion? YES  NO

History of Coronary Artery Disease? YES  NO  Comment: \_\_\_\_\_

Hepatitis B Antigen: NEG  POS  HIV: NEG  POS

Has the patient had previous of malignant disease? YES  NO  If yes, what type? \_\_\_\_\_

Evaluated at another program: YES  NO  If yes, what type and where? \_\_\_\_\_

Previous Transplant: YES  NO  If yes, what type and when? \_\_\_\_\_

Other Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Fax or mail to:**  
Emory University Hospital  
McKelvey Lung Transplantation Center  
1364 Clifton Road, NE  
Suite C-607  
Atlanta, GA 30322  
Office: (404) 727-9650  
Fax: (404) 727-1516

