Re: Referral for lung transplant

Thank you for referring your patient to the Lung Transplant Program at NewYork Presbyterian Hospital Columbia University Irving Medical Center. Prior to scheduling your patient for an initial consultation, we will be reviewing your patient’s records for medical screening and insurance verification. To ensure a prompt review, please include the following required records at the time of initial referral. The records can be faxed, emailed, or mailed to us based on your preference:

Fax: (212) 342-1087

Email: Lungtransplant@nyp.org
Website: www.columbiasurgery.org/lung-transplant

Mail: ATTN: Intake Coordinator
Lung Transplant Program
New York Presbyterian Hospital
622 West 168th Street, PH 14 – RM 104
New York, NY 10032-3784

<table>
<thead>
<tr>
<th>Required Demographic, Insurance, and Medical information</th>
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</thead>
<tbody>
<tr>
<td>Fully completed Lung Transplant Patient Registration Form (attached).</td>
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<tr>
<td>Insurance Information. Please attach front and back copy of all medical insurance cards.</td>
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<tr>
<td>Clinical summary or most recent consult note including H &amp; P, medication list, and current BMI (Body Mass Index). Our maximum BMI limit for lung transplant evaluation is 40 kg/m².</td>
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<tr>
<td>PFTs within 12 months. If your patient is unable to perform PFT, please let us know.</td>
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<tr>
<td>Chest x-rays/CT reports in the last 3 years. Please include the CD of the images.</td>
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<td>Detailed smoking history (quit date/number of pack-years). Our program requires abstinence from all tobacco/nicotine use for a minimum of 6 months prior to being considered for transplant.</td>
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<tr>
<td>For patients with history of malignancy, please include the Oncology records.</td>
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Without reviewing the required patient information, we are unable to schedule your patient in a timely manner. We may request additional records if deemed necessary.
Please share this information with your office staff.

We look forward to working with you and taking part in your patient’s care. More information about our program is available to you and your patient at www.columbiasurgery.org/lung-transplant. If you have any questions or concerns please do not hesitate to call our office at (646) 317-4514 or email us at Lungtransplant@nyp.org to contact one of our friendly Intake Coordinators.

Best Regards,

Magdala Bernard
Katherine Tejeda
Intake Coordinators
Lung Transplant Program

Selim Arcasoy, MD, MPH
Professor of Medicine
Medical Program Director
Lung Transplant Program

Frank D’Ovidio, MD, PhD
Professor of Surgery
Surgical Program Director
Lung Transplant Program
Patient being referred for: □Lung TXP □Heart / Lung TXP
□Consultation (pt does not warrant or not considering lung transplant)

PATIENT INFORMATION

Please complete this form, filling each item. All information is strictly confidential.

Intake Date: ____________

Patient being referred for: □Lung TXP □Heart / Lung TXP
□Consultation (pt does not warrant or not considering lung transplant)

Patient Name: ___________________________ Date of Birth: __________ Gender: □Male □Female Age: ______

Street Address: ____________________________________________________________

Marital Status: □Single □Mar □Div □Widow Primary Language: __________________ Race: _________ Ethnicity: ______________

Social Security #: ____________________ Home Telephone: ____________________ Cell #: __________________

Email: ________________________________

Mother’s First Name: ____________________ Father’s First Name: ____________________

EMERGENCY CONTACT

Name ____________________________ Phone #: ____________________ Relation: □Spouse □Parent □Son □Daughter □Other

INSURANCE INFORMATION

Copy of insurance card required

Primary Insurance: _________________________ □EPO □HMO □PPO □OTHER ____________________

Policy Number: __________________________ Group Number: __________________________

Subscriber’s name: ________________________ Subscriber’s S.S # __________ D.O.B.: __________

Relation to patient: □self □spouse □child □other ________________ Home Telephone: __________________

IF MEDICARE IS PRIMARY PATIENT MUST HAVE A SECONDARY INSURANCE

Secondary Insurance: _________________________ □EPO □HMO □PPO □OTHER ____________________

Policy Number: __________________________ Group Number: __________________________

Subscriber’s name: ________________________ Subscriber’s S.S # __________ D.O.B.: __________

Relation to patient: □self □spouse □child □other ________________ Home Telephone: __________________

OFFICE POLICY: IT IS THE PATIENT’S RESPONSIBILITY TO PROVIDE HIS/HER INSURANCE CARD AND TO NOTIFY US OF ALL CHANGES IN COVERAGE.

REFERING PHYSICIAN INFORMATION

Doctor: ____________________________ Practice Name: ____________________________ Street
Address: ______________________________________ Office Phone: ______________________

Office Fax: ________________________ UPIN: ___________________ DEA#

License #: ____________________ NPI #: __________________

PLEASE LIST ANY OTHER PHYSICIANS INVOLVED IN PATIENT CARE:

Doctor ____________________________ Office Phone: ____________________________

Doctor ____________________________ Office Phone: ____________________________

Doctor ____________________________ Office Phone: ____________________________

Doctor ____________________________ Office Phone: ____________________________

Doctor ____________________________ Office Phone: ____________________________

Doctor ____________________________ Office Phone: ____________________________

Doctor ____________________________ Office Phone: ____________________________