Lung Transplantation Program
New York-Presbyterian Hospital
Columbia University Irving Medical Center
TEL (1) 212 305 4881 (2) 212 342 1972
FAX 212 342 1087

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

Required Demographic, Insurance, and Medical information

___ Fully completed Lung Transplant Patient Registration Form (attached).
___ Insurance Information. Please attach front and back copy of all medical insurance cards.
___ Clinical summary or most recent consult note including H & P, medication list, and current BMI (Body Mass Index). Our maximum BMI limit for lung transplant evaluation is 40 kg/m2.
___ PFTs within 12 months. If your patient is unable to perform PFT, please let us know.
___ Chest x-rays/CT reports in the last 3 years. Please include the CD of the images.
___ 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.
___ For patients with history of malignancy, please include the Oncology records.

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

Philippe Lemaitre, MD, PhD
Surgical Program Director
Lung Transplant Program

Lung Transplant Program Patient Registration Form

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 Information – Please print clearly and complete all fields
Patient Diagnosis: ____________
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: ____________ Office Fax: ____________
Doctor ____________ Office Phone: ____________ Office Fax: ____________