NewYork-Presbyterian
WITH WORLD-CLASS DOCTORS FROM COLUMBIA Weill Cornell Medicine

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 (212) 305-4881 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

NewYork-Presbyterian Columbia University Irving Medical Center

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 ☐ Married ☐ Divorced ☐ 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
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: ☐

Office policy: it is the patient's responsibility to provide his/her insurance card and to notify us of all changes in coverage.

Referring 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: ☐