NewYork-Presbyterian
The University Hospitals of Columbia and Cornell

Lung Transplantation Program
New York-Presbyterian Hospital
Columbia University Medical Center
622 West 168th Street, PH14, Room 104
New York, NY 10032

TEL (1) 212 305 4881 (2) 646 317 4514
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/m^2.
____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

Frank D'Ovidio, MD, PhD
Professor of Surgery
Surgical Program Director
Lung Transplant Program

Lung Transplant Program - New York Presbyterian Hospital of Columbia University Medical Center

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: _____