

Re: Referral for lung transplant

Thank you for referring your patient to the Lung Transplant Program at New York 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](mailto:Lungtransplant@nyp.org)

**Website:** [www.columbiasurgery.org/lung-transplant](http://www.columbiasurgery.org/lung-transplant)

**Mail:** ATTN: Intake Coordinator  
Lung Transplant Program  
New York Presbyterian Hospital  
622 West 168<sup>th</sup> 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 35 kg/m<sup>2</sup>.
- \_\_\_ 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](http://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](mailto:Lungtransplant@nyp.org) to contact one of our friendly Intake Coordinators.

Best Regards,

Tanisha Selden  
Karrah Barksdale  
Intake Coordinators  
Lung Transplant Program

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

Frank D'Ovidio, MD, PhD  
Associate 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.**

**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: \_\_\_\_\_