



**Lung Transplant Center
Referral Form**

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Lung Transplant Center

Phone: 843-792-5097

Fax: 843-792-7845

FAX TO: 843-792-7845

If you have any questions in facilitating a referral, please call us at 843-792-5097.

Patient Information

Name: _____

Diagnosis: _____ Reason for Referral: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Address: _____

DOB: _____ Gender: _____ Race: _____ SSN (required): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____ Smoking cessation date, if applicable: _____

Please attach the following records if available:

- Pulmonary Function Tests (include up to past 5 years)
- Referring physician's notes (include up to past 5 years)
- Cardiac Testing
 - Heart catheterization
 - Stress test
 - ECHO
 - MRI
 - EKG
- Serum labs within the last year
- Sputum cultures within the last year
- Women: PAP smear for age ≥18; Mammogram for age ≥40 of positive history
- Men: Current PSA age ≥50
- GI: Endoscopy or Colonoscopy for positive history or age ≥50
- Chest Imaging (X-ray and CT scan reports)
- Immunization records
- DEXA (bone density) scan

Insurance Information

(please include copy of patient's insurance card)

Primary Insurance name and phone: _____

Policy Holder's Name: _____ Policy #: _____ Group #: _____

Referring Provider Information

Name: _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

How did you hear about MUSC? _____

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