UW Medicine

University of Washington
Lung Transplant Referral Form

Mailing Address: 1959 NE Pacific Street, Box 356175
Seattle, WA 98195-6175

Phone: 206-598-5277 **Fax: 206-598-3425**

This form has been designed to streamline the referral process and transplant assessment.
Please fax completed form and documents to: 206-598-3425
Any questions should be directed to the transplant team at 206-598-5277. Thank you for your cooperation.

****Absolute contraindications for lung transplant: Active smoking, BMI ≥ 35****
If your patient does not have the above absolute contraindications, proceed with completing this form.

****Please consider the following when submitting a referral for consideration of lung transplantation****

- ✓ Patients must have 2 non-smoking, adult caregivers who are able to drive and available to provide care 24/7 for at least the first 3 months after surgery (secondary caregiver must be able to fulfill this role if the primary caregiver is unable/unavailable) – please note caregiver may NOT provide care to others while fulfilling this role (i.e. children, other adults, etc.)
- ✓ Patients must plan to live within 1 hour of Seattle for at least 3 months following the transplant surgery.

- Please complete all sections – any questions that are not applicable or available should be marked **"N/A"**
- When specific results are not available, but have been requested, please mark as **"pending"**

Patient Demographic Information

Name:				Gender:		Veteran?	☐ Yes ☐ No
Address:						Marital Status:	
City:				State:		Zip:	
SSN:				DOB:		Race:	
Home Phone:				Work Phone:			
Cell Phone:				E-mail:			
Emergency Contact:				Phone:		Relationship:	
Language:		Interpreter?	☐ Yes ☐ No	Special Needs?	☐ No ☐ Yes (explain):		
Employer:							

Physician Information

Referring Physician:					Primary Care Physician:				
Practice/Group Name:					Practice/Group Name:				
Address:					Address:				
City:		State:		Zip:	City:		State:		Zip:
Phone:					Phone:				
Fax:					Fax:				
E-mail:					E-mail:				
Name of Person Completing this Form:									

Primary Insurance Information (or copy of insurance card)

Company:		Policy ID:		Group Number:	
Policyholder's Name:		Policyholder's DOB:			
Insurance Phone Number:		Referral or Pre-Cert Number:			

Secondary Insurance Information (or copy of insurance card)

Company:		Policy ID:		Group Number:	
Policyholder's Name:		Policyholder's DOB:			
Insurance Phone Number:		Referral or Pre-Cert Number:			

Required Medical Information

****Please note, the following information may be outlined in a clinic note or letter but must include all elements****

Primary Diagnosis:					
Reason for Referral:		**Note:** This may include accelerating progression of disease, increasing frequency of exacerbations, hemoptysis, worsening symptoms, etc.			
Patient Height:	cm	Patient Weight:	kg	Date of Last Measurement:	
O_2 use at rest:		O_2 use at night:		O_2 use with exertion:	
Smoking Cessation Date:		**Note**: For smoking/nicotine cessation <1 year, patients will be required to have 6 months of random monthly nicotine screening tests in order to be eligible to be placed on the transplant waiting list – please complete at least 2 screening tests prior to submitting referral.			
Marijuana Use?	☐ Yes ☐ No	If "yes":	Route:	Frequency:	
			Quantity:	Indication (i.e. appetite):	
Participation in Pulmonary Rehab?	☐ Yes ☐ No	**Note**: If the patient has not participated in pulmonary rehab or has not participated in >1 year, please refer patient to local pulmonary rehab program.			
Frequency of Exacerbations (if applicable)? Please indicate inpt vs. outpt.	☐ 1-2 per year ☐ 3-4 per year ☐ 5-6 per year ☐ >6 per year ☐ Nearly continuous for months Comments:				
Any additional important medical or surgical information that may pertain to transplant candidacy?	☐ Yes ☐ No	If "yes" explain:		**Note**: This may include history of cancers, immune disorders, history of thoracic surgery, other significant organ disease, chronic narcotic/substance abuse, etc.	
Assessment of patient adherence to and engagement with medication regimens, clinic visits, good health measures, etc. *Clinician Rating Scale (Kemp et al, BMJ 1996)	☐ Complete refusal				
	☐ Partial refusal				
	☐ Accepts only because compulsory, very reluctant/requires persuasion, or questions the need for medication often				
	☐ Occasional reluctance				
	☐ Passive acceptance				
	☐ Moderate participation, some knowledge and interest in medication with no prompting required				
	☐ Active participation, readily accepts and show responsibility for regimen				
	Explain if needed:				

Please attach the following **REQUIRED** records:

- Pulmonary Clinic notes for the last 2 years, including list of current medications
- Hospital Discharge Summaries for the last 2 years, if applicable
- Pulmonary function tests for the last 2 years
  - Must have testing done within the previous 6 months prior to referral; if updating PFTs for referral, please also perform DLCO and lung volumes.
- Six-minute walk test with oxygen titration
- Serum labs within the last 6 months, including CBC and creatinine
- Immunization record
- **FOR PATIENTS WITH CYSTIC FIBROSIS, BRONCHIECTASIS, OR WITH CHRONIC AIRWAY COLONIZATION:** Include respiratory cultures for the last 2 years and comment on growth of *B. cenocepacia* or *M. abscessus* at any time in the past (include culture reports).
  - **Comment:**

Other testing/notes **if previously performed** (do *not* need to complete testing for referral if not previously performed):

- Overnight oximetry and/or sleep study report(s)
- Recent CT chest and chest X-ray report(s)
- ABG/ VBG
- Echocardiogram
- Left and/or right heart catheterization and/or stress test
- Cardiac or thoracic operative notes
- Lung pathology reports
- Esophageal studies (esophagram, gastric emptying study, pH study, manometry, etc.)
- Social work and/or nutrition notes