

**COLUMBIA PRESBYTERIAN MEDICAL CENTER
LUNG TRANSPLANT PROGRAM**

622 WEST 168TH STREET, PH 14-104
NEW YORK NY 10032-3720
PHONE: 212-305-7771
FAX: 212-342-5382

FACSIMILE COVER SHEET

To:

From:

Selim Arcasoy, M.D.
Joshua Sonett, M.D.

FAX NUMBER:

Date:

COMPANY:

TOTAL NO. OF PAGES INCLUDING COVER:

PHONE NUMBER:

SENDER'S REFERENCE NUMBER:

Re:

YOUR REFERENCE NUMBER:

Patient referral packet

URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY

NOTES/COMMENTS:

To facilitate the referral process, we request that you complete the following demographic information sheet. Unfortunately clearance can not start with out it. Please forward the completed sheet via fax along with all medical records and a copy of your patient's insurance card(s). Upon receipt, the patient will be medically and financially reviewed. We will then contact the patient for an appointment via mail.

Thank you for referring your patient to us.

Selim Arcasoy, M.D.
Medical Director
Lung Transplantation Program

Joshua Sonett, M.D.
Surgical Director
Lung Transplant Program

This information is being released to a physician for urgent patient care.

CONFIDENTIALTY NOTICE

If you are the intended recipient of this information you may use or disclose Protected Health Information attached only as permitted or required by HIPPA regulation. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.

CONFIDENTIALTY/DISCLOSURE WARNING: This transmittal contains **PRIVILEGED AND CONFIDENTIAL** information intended for use by a physician. Use, copying, or distributing by any other person is strictly prohibited. If you have received this transmittal in error, please notify us by telephone at (212) 305-7771. Thank-you

Dear Doctor,

Thank you for referring your patient to the Lung Transplant Program at the New York-Presbyterian hospital and for entrusting us with their care. In order to facilitate the referral process, please provide the following information at your earliest convenience:

Necessary information/records:

- Patient Registration Form
- Primary Language _____
- Insurance Card Copy (front and back)
- Medical History
- Introductory Letter
- Chest x-rays Reports
- CT Scan Reports (Most recent)
- PFT reports

Optional records if available:

- Cardiac Catheterization Report
- Echo
- MUGA
- Sputum Cultures (within the last year)
- VQ Scans (within the last year)
- Pathology reports
- PET Scans
- CT or Chest x-ray Films
- Biopsy Slides

Incomplete records may delay our evaluation of your patient.

The evaluation for lung transplantation is an intensive and complex process. It usually requires several weeks to perform multiple tests and several outpatient visits. When the process had been completed, we will contact you concerning the results of your patient's testing and our recommendations regarding his/her suitability for transplantation.

If your patient hasn't heard from us within 4 weeks of referral, please do not hesitate to call our office @ (212) 305-7771 and speak to one of our clinicians.

The referral process can be expedited for sicker patients; therefore a phone call to one of the clinicians in our program is encouraged when referring ailing patients.

Please fax or Fed Ex all information to the attention of:

Referral Department:
Lung Transplant Program
New York-Presbyterian Hospital
622 West 168th Street, Ph 14 Room 104
New York, NY 10032
Fax: 212-342-5382

Please contact anyone in our staff with any additional questions. Thank You.

Selim Arcasoy, M.D.
Medical Director
Lung Transplant Program

Joshua R. Sonett, M.D.
Surgical Director
Lung Transplant Program

Lung Transplant Program

New-York Presbyterian Hospital of Columbia University Medical Center

REGISTRATION FORM

Please answer all questions

Date: ____/____/____

PATIENT INFORMATION

Patients Name: _____ D.O.B.: _____ Age: _____ Sex: M F Religion: _____

Marital Status: Single. Mar. Div. Primary Language: _____ Patient Diagnosis: _____

Father's Name: _____ Mother's Name: _____ Social Security #: _____ Home phone #: _____

Home address: _____

Occupation: _____ Employer: _____ Work#: _____

Emergency Contact name: _____ Telephone# _____ Relationship to patient: spouse friend relative

INSURANCE INFORMATION

Primary Insurance

EPO HMO PPO POS Other _____

Type of Plan _____ Policy # _____ Plane Name _____

Subscriber's name: _____ Responsible for party _____ Subscriber's S.S # _____

Subscriber's D.O.B.: _____ Patient's relationship to subscriber: spouse self child other _____

Secondary Insurance

EPO HMO PPO POS Other _____

Type of Plan _____ Policy # _____ Plane Name _____

Subscriber's name: _____ Responsible for party _____ Subscriber's S.S # _____

Subscriber's D.O.B.: _____ Patient's relationship to subscriber: spouse self child other _____

PHYSICIAN INFORMATION

Referring Physician

Name: _____

Address: _____

Office # _____

Office fax# _____

UPIN # _____

License # _____

DEA # _____

Cardiologist

Name: _____

Office # _____

Office fax# _____

Address: _____

Primary Care Physician

Name: _____

Office # _____

Office fax# _____

Address: _____