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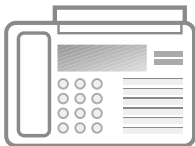
Lung Transplant Program

NewYork-Presbyterian Hospital/Columbia
University Medical Center

622 West 168th Street, Ph-14

New York, NY 10032-3784

TEL 212 305 7771



Dear

Fax number:

Office number:

From: Selim Arcasoy, M.D./Joshua Sonett, M.D.

Date:

Regarding:

Total No. of pages including cover sheet:

Comments:

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.

To facilitate the referral process, we request that you complete the following demographic information sheet and provide us with the requested medical records on your patient. Unfortunately clearance can not start without the necessary documentation.

Please forward the completed sheet via fax or fed-ex 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. Please do not fax more than 25 pages. If medical chart is more than 25pgs, please forward 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

LUNG TRANSPLANT PROGRAM

New-York Presbyterian Hospital of Columbia University Medical Center

PATIENT REGISTRATION FORM

Please complete this form, filling in 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

Patient Diagnosis: _____

Patient Name: _____ Date of Birth: _____ Gender: Male Female Age: _____

Street Address: _____

Marital Status: Single Mar Div Widow Primary Language: _____

Social Security #: _____ Home Telephone: _____ Cell # _____

Mother's First Name: _____ Father's First Name: _____

EMERGENCY CONTACT

Name _____ contact#: _____ Relation: spouse parent son daughter other

INSURANCE INFORMATION COPY OF CARDS REQUIRED FOR BILLING

Primary Insurance

EPO HMO PPO POS Other _____

Type of Plan _____ Policy # _____ Group# _____

Secondary Insurance

EPO HMO PPO POS Other _____

Type of Plan _____ Policy # _____ Group# _____

Policy Holder Information (If different from patient information)

Subscriber's name: _____ Subscriber's S.S # _____ Subscriber'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.

PHYSICIAN INFORMATION

Referring Physician

Dr: _____ Practice Name: _____

Street Address: _____

Office Phone: _____ Office Fax: _____

UPIN: _____ DEA# _____ License #: _____ NPI #: _____

Primary Care Doctor (if different than Ref. M.D)

Dr: _____ Street Address: _____

Office Phone: _____ Office Fax: _____

PLEASE LIST ANY OTHER PHYSICIANS INVOLVED IN YOUR CARE:

Dr. _____ Office Phone: _____ Office Fax: _____

Dr. _____ Office Phone: _____ Office Fax: _____

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:

Incomplete records will delay our evaluation of your patient.

Necessary information/records:

- | | |
|--|--|
| <input type="checkbox"/> Patient Registration Form | <input type="checkbox"/> Introductory Letter |
| <input type="checkbox"/> Primary Language _____ | <input type="checkbox"/> Recent chest x-rays reports |
| <input type="checkbox"/> Insurance Card Copy (front and back) | <input type="checkbox"/> Recent CT scan reports |
| <input type="checkbox"/> Current office visit note with H&P | <input type="checkbox"/> Recent PFT reports |

Optional records if available:

- | | |
|---|--|
| <input type="checkbox"/> Cardiac Catheterization Report | <input type="checkbox"/> Pathology reports |
| <input type="checkbox"/> Echo | <input type="checkbox"/> PET Scans |
| <input type="checkbox"/> MUGA | <input type="checkbox"/> CT or Chest x-ray Films |
| <input type="checkbox"/> Sputum Cultures (within the last year) | <input type="checkbox"/> Biopsy Slides |
| <input type="checkbox"/> VQ Scans (within the last year) | |

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

The evaluation for lung transplantation is an intensive and complex process. It usually requires an initial consultation; 1) to determine if you are a suitable candidate for transplantation and 2) to educate you and your family about all aspects of lung transplantation. After completion of the initial consultation, a letter summarizing the results of this initial evaluation will be sent to the referring physician. If the initial evaluation indicates your patient may benefit from lung transplantation, then they will be required to undergo a battery of tests. When the process has been completed, we will contact you concerning the results of your patient's testing and our recommendations regarding his/her suitability for transplantation.

If you have any questions, please do not hesitate to call our office @ (212) 305-7771 and speak to one of our clinicians. 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