



Heart Transplant Patient Referral Form

Please complete the referral form in its entirety. If received without all information requested, or information is not legible, a letter of referral hold for 14 days will be sent to the patient and referring provider. If requested information is not received in 30 days, the referral will be closed. The patient will be eligible for re-referral after 6 months. Send referrals to UMMC Fax number: 601-984-2962

Patient Name: _____ DOB: _____ Sex: Male Female Race: _____
Phone: _____ Address: _____ City: _____ State: _____ ZIP: _____
Social Security: _____ - _____ - _____ Height: _____ Weight: _____ BMI: _____
Patient's Insurance: _____ UMC MRN(if available): _____

Reason for Referral: _____

Does the patient smoke? Yes No Unknown

Does the patient have compliance, psychosocial, substance abuse problems/issues which you feel would negatively impact outcomes of heart transplant or would be relevant to the evaluation: No Yes

If yes, explain: _____

Referring Physician Information

Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____ Contact Person: _____

Required information for referral:

History and Physical -within the last 12 months

Recent Clinic Notes Chest-Xray

Echocardiogram EKG

Cath Reports Recent Discharge Summary

Recent labwork Current medication list

***Once the referral is received, the patient will receive a phone call followed by a letter with an appointment. The referring provider will also receive notification once appointment is scheduled.

***Copy of Insurance card front and back**

Please send results IF the patient has had any of the following:

- | | |
|-------------------------------------|--|
| Flu, pneumonia, Hep B immunizations | Previous testing available in past 12 months that may contribute to evaluation |
| TB Skin test (most current) | Pap smear (females 18 y/o and older) |
| Signed Release of Information Form | Mammogram (40 y/o and older) |
| Care Plan, current | Colonoscopy; men and women in last 5 years |
| Ultrasound Reports | Nuclear Reports, MRI, or CT Scans |
| Signed Request for Information | |

Please note: the patient must have a support person 18 y/o or older accompany them to their heart transplant appointments