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

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

***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.

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

University of Mississippi Medical Center - 2500 North State Street - Jackson, MS 39216

Patient Care 601-984-5065 Transplant Referral Fax: 601-984-2962