

**LUNG TRANSPLANT REFERRAL FORM
TORONTO LUNG TRANSPLANT PROGRAM
TORONTO GENERAL HOSPITAL**

**FAX: Transplant Assessment Office
416-340-3097**

Referring MD:

Address:

Phone:

Fax:

E-mail:

May we use email to contact you about this patient?

Yes

No

Billing number:

Date of referral:

PATIENT'S NAME:

ADDRESS:

PHONE: (H)

(W)

Date of Birth:

Health card number:

Family physician's name/contact information:

Current Height:

Weight:

BMI:

Smoking history:

Date quit:

Past medical history:

Please attach letter detailing history of respiratory disease and course of treatment.

Current Medications:

Cardiac studies (check if report attached):

- include 2D echo report on all patients >60 years AND those with pulmonary vascular disease
- include nuclear cardiac stress test report on all patients >60 years
- include heart cath report if available

Pulmonary studies (check if reports attached):

- pulmonary function tests
- chest imaging reports

Transplant MD office use only:

Date/time of office visit:

6 Minute walk:

PFT:

Tele-health:

Pt. Notified:

Date referral received in assessment office:

Registered in OTTR: