

Shands Hospital Lung Transplant Program At The University of Florida
P.O. Box 100395, 1600 SW Archer Rd - Room 2194
Gainesville, FL 32610
Phone: 352-265-8940 Fax: 352-265-8970

NEW PATIENT REFERRAL FORM

Date: _____ SSN: _____ Insurance Carrier: _____

DOB (Age): _____ Wt: _____ Ht: _____ Policy #: _____

Name: _____ Phone: _____

Address: _____ Secondary Ins: _____

City/State/Zip: _____ Policy #: _____

Telephone: _____ Phone: _____

DIAGNOSIS: _____

*PLEASE FAX CURRENT H&P AND/OR CLINIC NOTES, PFT RESULTS
(VOL, DLCO & ABG) AND CXR/CT SCAN RESULTS WITHIN LAST YEAR.*

Smoking Hx: _____ years x _____ PPD Quit Smoking Yes _____ No _____

Date last smoked: _____

O2: _____ Yes _____ No _____ O2: _____ L/Min

Referring M.D.: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Fax: _____