

Lung, Heart/Lung Transplant Referral
Phone: 650-724-7338
Fax: 650-724-6242
Email: LungTxpReferrals@stanfordhealthcare.org

Referring Provider Information

Referring Provider Name		Referring Provider Email		Date
Office Address			NPI Number (Required for new referring provider)	
City		State	ZIP Code	Phone
Fax	Primary Care Provider (optional)			

Primary Care Provider (optional)	Specialist
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Patient Information

Patient Name <i>(First, Middle, Last)</i>			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address			County (optional)
City		State	ZIP Code
Home Phone		Alternative Phone	Parent Name (if minor)
Maiden Name		Spouse's First Name (optional)	
Patient Insurance Information (if available)		Does the patient need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what Language?	
Is the request related to: <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Litigation <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> N/A			

Appointment Request

Please submit any pertinent medical records or testing available (i.e. PFT, CT, walk test, echo).
Reason for referral/symptoms/diagnosis:

Thank you for referring your patient to Stanford Health Care – Lung, Heart/Lung Program.