

# Memorial Hermann Texas Medical Center

## Lung Transplant & Pulmonary Referral Form

Date: \_\_\_\_\_

If patient's demographic form is not available, please fill out the following information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ ☐ Male ☐ Female

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_

Language Preference: ☐ English ☐ Spanish ☐ Other: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

### Referring Provider Information:

Referring Physician: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Office Phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_

Reason for Referral / Diagnosis: \_\_\_\_\_

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

Provider Signature	Print Name	NPI/MHHS ID.	Date	Time	Contact No.
_____	_____	_____	_____	<input type="checkbox"/> AM <input type="checkbox"/> PM	_____

The patient will be contacted within 48 business hours to confirm that we have received your referral.

Please fax the completed form to 713.704.0984. Include copy of Insurance cards and medical records.

- Office visit/Clinic Note
- Pulmonary Function Test (PFT), 6 minute walk, Spirometry
- Bronchoscopy report & biopsy
- Heart Catheterization (LHC/RHC/PCI) report
- ECHO/ TTE/ TEE (echocardiogram) report
- Chest imaging reports (CT/CTA/X-ray/Cardiac MRI/Cardiac PET/Lung VQ scan)
- Stress Test/Nuclear stress/Exercise stress/Myocardial perfusion imaging/PET stress
- Sleep study
- Labs
- Vaccination list
- Records from any pulmonary related hospitalizations, if available

Our Clinic: Memorial Hermann–Texas Medical Center, 6400 Fannin Street Suite 2500, Houston, Texas 77030

Referral Phone # 713.704.5352

Referral Fax # 713.704.0984 Referral Email: ACTAT@memorialhermann.org

### Confidentiality Notice

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Texas Medical Center

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