UVAHealth

Charles O. Strickler Transplant Center
Heart Transplant/VAD Referral Form

Fax to: Stacey Snoddy **Fax #: 434-243-7733**

(Please Print)

❑ **Heart Only** ❑ **LVAD and Heart** ❑ **LVAD Only**

Today's date:	Name of Practice:		
Address:		Phone: ( )	Fax: ( )
Referring Provider:		**Contact Person:**	
PCP (if different from referring):			

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Sex ❑ M ❑ F	Birth Date / /	Soc. Security Number __ __ __ - __ __ - __ __ __ __
Street address:			PO Box:		Home phone: ( )
City:	State:	ZIP Code:	Work phone: ( )		Cell phone: ( )
Name Additional Contact:	Relation to Patient:		Primary phone: ( )		Cell phone: ( )
Race:	Ethnicity:		Preferred language: Interpreter needed: ❑ Y ❑ N		Marital Status:

INSURANCE INFORMATION

(Please Include Copy of Insurance Card)

Is this patient covered by insurance?	❑ Yes	❑ No		
Please indicate primary Insurance:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:

PLEASE INCLUDE THE FOLLOWING AVAILABLE RECORDS

❑ Recent History & Physical ❑ 3 Months Clinic Notes ❑ CXR Results ❑ All Path Reports ❑ Immunizations	❑ Cardiac Cath ❑ Echo ❑ EKG ❑ CT Chest/ABD/Pelvis ❑ PFTS/6 minute walk ❑ Any cardiac surgeries OP notes	❑ Perfusion Scans ❑ Peripheral vascular studies ❑ Carotid US studies ❑ Colonoscopy ❑ Mammogram (female) ❑ Pap Smear (female)	**Most Recent Lab Results** ❑ Chemistries ❑ Hematology ❑ ABO ❑ 24 hour Urine/Creatinine Clearance ❑ PSA (males)

PO Box 800265, Charlottesville, VA 22908 **Phone: 434-924-0153 or 1-800-257-0757**