Stanford MEDICINE

Health Care

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

Patient Information

Patient Name *(First, Middle, Last)*				Sex ☐ Male ☐ Female
Address				County (optional)
City		State	ZIP Code	Birth Date *(Month DD, YYYY)*
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? ☐ Yes ☐ No If yes, what Language?		
Is the request related to: ☐ Motor Vehicle Accident ☐ Litigation ☐ Worker's Compensation ☐ 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.