

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: _____

Provider Signature	Print Name	NPI/MHHS ID.	Date	Time	Contact No.
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AM
 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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Lung Transplant & Pulmonary
Referral Form

