# CYSTIC FIBROSIS LUNG TRANSPLANT TEMPLATE REFERRAL FORM

This template reflects the type of information that most lung transplant centers need from the referring CF team to initiate the referral process. Please check with the lung transplant program for center-specific requirements.

| PATIENT DEMOGRAPHIC INFORMATION | | | |
|---|---|---|---|
| Name: | | Gender: | Veteran: ☐ Yes ☐ No |
| Address: | | | Marital Status: |
| City: | | State: | Zip: |
| SSN: | | DOB: | Race: |
| Phone - Home: | | Phone - Work: | |
| Phone - Cell: | | Email: | |
| Emergency Contact: | | Phone: | Relationship: |
| Language: | Interpreter: ☐ Yes ☐ No | Special Needs: ☐ Yes ☐ No If yes, explain: | |
| ☐ Employed ☐Unemployed ☐Retired ☐Disabled | | | |
| Employer (if applicable): | | | |

| PHYSICIAN INFORMATION | | |
|---|---|---|
| Name and Contact of Person Completing This Form: | | |
| Physician - Referring: | CF Center (if applicable): | |
| Practice/Group Name: | Address: | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |

| | | |
|---|---|---|
| Physician - Primary Care: | | |
| Practice/Group Name: | Address: | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |

| PRIMARY INSURANCE INFORMATION (☐ or check box if copy of insurance card is included) | | |
|---|---|---|
| Company: | ID - Policy: | ID - Group: |
| Policyholder's Name: | Policyholder's DOB: | |
| Insurance Phone: | Referral or Pre-Cert Number: | |
| Name of Employer (if using private insurance): | | |
| Is an insurance case manager already assigned: ☐ Yes ☐ No | | |
| Public Insurance Information (if applicable): | | |

| SECONDARY INSURANCE INFORMATION (☐ or check box if copy of insurance card is included) | | |
|---|---|---|
| Company: | ID - Policy: | ID - Group: |
| Policyholder's Name: | Policyholder's DOB: | |
| Insurance Phone: | Referral or Pre-Cert Number: | |

## REQUIRED MEDICAL INFORMATION

| Primary Diagnosis: | CFTR Genotype (e.g., F508del/F508del): |
|---|---|

Reason for Referral:

This may include accelerating progression of disease, increasing frequency of exacerbations, hemoptysis, worsening symptoms, etc.

| Height (cm): | Weight (kg): | BMI: |
|---|---|---|

Nutritional Status/Management (trajectory of BMI, presence of G-tube, type/frequency of oral supplements):

If G-tube, list insertion date and type/frequency of supplements:

| CFRD: ☐ Yes ☐ No | Insulin: ☐ Yes ☐ No |
|---|---|

Supplemental Oxygen Requirement: ☐ None ☐ At night, __ LPM ☐ With exertion, __ LPM ☐ At rest, __ LPM

Noninvasive Ventilation (e.g., BiPAP use): ☐ None ☐ At night (settings: ____/____)

Kidney Disease: ☐ Absent ☐ Present, recent creatinine ____ (date _____ )

Liver Disease: ☐ Absent ☐ Present, without cirrhosis ☐ Present, with cirrhosis

| Marijuana Use: ☐ Yes ☐ No ☐ Unknown | If "yes": ☐ Medical ☐ Recreational | |
|---|---|---|
| | Route: | Frequency: |
| | Indication (e.g. appetite): | |

| Smoking Status: ☐ Unknown ☐ Active ☐ Former, cessation date _____ ☐ Never | Participation in Pulmonary Rehab: ☐ Yes ☐ No |
|---|---|

Frequency of Exacerbations in the Past 12 Months: ☐ # Inpatient: ___ ☐ # Outpatient: ___ ☐ Near continuous for ___ months

Any additional important information that may pertain to transplant candidacy: ☐ Not Applicable

This may include history of depression, anxiety, cancers, immune disorders, thoracic procedures, other significant organ disease, chronic narcotic/substance use, etc.

Does the patient have a history of non-adherence to medical recommendations: ☐ Yes ☐ No

Does the patient lack an adequate support system (e.g., post-transplant caregivers): ☐ Yes ☐ No

If yes to either, please describe or discuss with lung transplant team directly. The importance of adherence and social support post-transplant can be a focus for pre-transplant education.

## PLEASE ATTACH THE FOLLOWING REQUIRED RECORDS:

- ☐ Pulmonary clinic notes for the last 2 years, including list of current medications
- ☐ Hospital discharge summaries for the last 2 years, if applicable
- ☐ Start and end dates of exacerbations (duration of antibiotics) for the past 12 months
- ☐ Pulmonary function tests for the last 2 years
  Must have testing done within the previous 6 months prior to referral; if updating PFTs for referral, please also perform DLCO and lung volumes.
- ☐ Six-minute walk test with oxygen titration
- ☐ Lab results within the last 6 months, including CBC, creatinine, liver function tests, and VBG (ABG, if performed)
- ☐ Immunization record
- ☐ For the last 2 years, send cultures for bacterial, fungal, and AFB
- ☐ For anytime in the past, send cultures if there has ever been growth of *B. cenocepacia* or *M. abscessus*. Please comment below:

## OTHER TESTING/NOTES IF PREVIOUSLY PERFORMED (DO *NOT* NEED TO COMPLETE TESTING FOR REFERRAL IF NOT PREVIOUSLY PERFORMED):

- ☐ Overnight oximetry and/or sleep study report(s)
- ☐ CT chest and chest X-ray report(s)
- ☐ Echocardiogram
- ☐ Left and/or right heart catheterization and/or stress test
- ☐ Cardiac or thoracic operative notes
- ☐ Esophageal studies (esophagram, gastric emptying study, pH study, manometry, etc.)
- ☐ Notes - Social work (last 2 years)
- ☐ Notes - Nutrition (last 2 years)
- ☐ Evaluation for liver disease/cirrhosis (ultrasound, MRI, CT, or biopsy)