

Pediatric Transplant Center

Lung Transplant Program Referral Form

Please return completed Referral Form to:
Children's Hospital Boston
Attention: Dawn Freiberger, RN, MSN
300 Longwood Avenue, Hunnewell 2
Boston, MA 02115

Tel # 617-355-6681

Fax # 617-730-0097

Demographic Information

Last Name _____ First Name _____ DOB _____
Age _____ SS# _____ Home Tel # _____
Home Address _____ Apt. # _____
City/Town _____ State _____ Zip Code _____
Name of Parent/Guardian _____
Home Address _____ Apt. # _____
City/Town _____ State _____ Zip Code _____
Home Tel # _____ Work Tel # _____ Cell # _____

Insurance Information

Primary Insurance _____ Subscriber Name _____
Group # _____ Policy # _____
Secondary Insurance _____ Subscriber Name _____
Group # _____ Policy # _____

Physician Information

Primary Care Physician _____ Tel # _____ Fax # _____
Address _____ City _____ State _____ Zip Code _____
Referring Physician _____ Tel # _____ Fax # _____
Address _____ City _____ State _____ Zip Code _____

Clinical History

Diagnosis _____
Events Prompting Referral _____

Pediatric Transplant Center

Has the patient experienced or been diagnosed with any of the following?			
Diabetes	Thoracic Surgery	Hemoptysis	Arrythmia
Heart Disease	Abdominal Surgery	ABPA	CO2 Retention
Prolonged Steroid Use	Liver Dysfunction	Renal Dysfunction	Pneumothorax
Asthma	GERD	Chronic Sinusitis	Sinus Surgery
Feeding Tube	Type _____	Central Venous Catheter	Type _____
Comments: _____			

Allergies: _____ _____ _____	<p style="text-align: center;"><u>Chest PT Vest</u></p> How often? _____ Does the patient use any supplemental oxygen? _____ How much? _____ How often? _____ Assisted Ventilation: BIPAP CPAP Does the patient supplement their diet? Scandishakes Tube Feedings What kind? _____ How often? _____
Medications: _____ _____ _____ _____ _____ _____ _____ _____	

<u>Physical Exam</u>
Significant findings on exam: _____ _____ _____
Most Recent Pulmonary Function Tests: Date: _____ FCV _____ FEV1 _____ MMFR _____
Most Recent Arterial Blood Gas: Date: _____ pH _____ PaCO2 _____ PaO2 _____ SaO2 _____ FiO2 _____

Please include the following in your referral:

- Recent sputum cultures and sensitivities
- Copies of most recent chest radiograph and CT scan
- A copy of the most recent clinic note or hospital discharge summary
- A copy of the most recent lab data