Heart Transplant
Physician Referral Form

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Inpatient transfer request? Yes ◯ No ◯

If urgent consultation is needed, please call **614-293-4444**.

UHOS20170142: Updated 5/8/17

Please fill out this form completely, include any clinical documentation relevant to this referral, and fax all documents to **614-293-9038**.
Mail any additional imaging CDs and/or documentation to: **452 W. 10th Ave., Suite 5216, Columbus, OH 43210**.
To speak with a heart transplant coordinator, call **800-538-1886**.

◯ **Clinical Documentation included**
(Examples include: insurance cards, imaging, lab work, office procedures, office notes, etc.)

Patient Information:

First Name: | Middle Name: | Last Name:

Gender: | Marital Status: | Last 4-digits SSN#: | Date of Birth (mm/dd/yyyy): | BMI:

Primary Phone: | Email: | Primary Insurance: | Secondary Insurance:

Street Address:

City: | State: | Zip: | Country:

Details:

Reasons for Referral:

Preferred Physician or Provider Name if Applicable:

Department or Specialty Area:

◯ Consult or Second Opinion ◯ Transfer of Care

Referring Provider Information:

Provider First Name: | Provider Last Name:

Provider Title: | NPI Number:

Street Address: | City: | State:

Zip: | Phone: | Extension: | Fax:

Physician Signature: _____ Date: _____