HealthCare

Heart Transplant and Ventricular Assist Device Referral Checklist

Thank you for referring to the University of Kentucky Heart Transplant and Ventricular Assist Device (VAD) program. The following checklist is designed to streamline and expedite the referral and appointment process. Please include all information when referring a patient. To speak with a representative directly, call toll free 1-800-456-5287.
We appreciate your referral and look forward to working with you and your patients.

Referring contact information

- Name
- Address
- Phone Number
- Fax Number
- Email

Information about your patient

- Name
- Birthdate
- Address
- Phone Number
- Social Security Number
- Insurance Information

Your patient's complete medical history and records

- Medical History
- Surgeries/Procedures/ICD type and date of implant
- Medications and Allergies
- Discharge summary from recent hospitalization

Diagnostic test reports

- Cardiac Catheterization
- Echocardiogram
- Recent stress test (if applicable)
- Electrophysiology testing (if applicable)
- Colonoscopy (if applicable)
- Mammogram (if applicable)
- Pap smear (if applicable)

Please fax all information to (859) 257-7402 to Gill Heart Institute,
Attn: VAD/Heart Transplant Team, 800 Rose Street, Suite G100, Lexington, Kentucky 40536.

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University of Kentucky Transplant Center
Heart Transplant and Ventricular Assist Device Consultation Request Form

To refer a patient to the University of Kentucky Heart Transplant and Ventricular Assist Device program, please fax this form and your cover sheet to 859-257-7402. To speak with a representative directly, call toll free 1-800-456-5287. We appreciate your referral and look forward to working with you and your patients.

If available, please provide the following items with this fax:

- ❑ Patient demographic sheet
- ❑ Copy of insurance cards (front and back)
- ❑ Medication list
- ❑ Most recent laboratory results
- ❑ Previous cardiac testing
- ❑ Recent history and physical and/or discharge summaries

Patient Insurance

❑ Medicare ❑ Medicaid ❑ Private: _____

Patient Information

Last name _____ First name _____ Middle initial _____ Date of birth (month/day/year) _____

Mailing address _____ Social Security number _____

City _____ State _____ Zip _____ Sex ❑ Male ❑ Female

Maiden name _____ (_____) _____ Phone number

Interpreter needed? ❑ Y ❑ N Clinic location: ❑ Lexington ❑ Louisville (in collaboration with Norton Healthcare)

Referring Physician Information

Physician name _____ Contact name _____ (_____) _____ Phone number

Physician NPI number _____ Email _____

Address _____ (_____) _____ Fax number

City _____ State _____ Zip code _____ County _____

This form can be found online at www.ukhealthcare.uky.edu/transplant

University of Kentucky Transplant Center | 740 S. Limestone, Suite K300, Lexington KY 40536-0284 | Toll free: 800-456-5287

or in Lexington 859-323-4620, option1 | Fax: 859-257-7402