Vancouver Coastal Health
Promoting wellness. Ensuring care.

Solid Organ Transplant Clinic
Gordon & Leslie Diamond Health Center
5th Floor, 2775 Laurel Street, Vancouver BC V5Z1M9

Fax: 604.875.5236
Tel: 604.875.5182

Lung & Heart/Lung Transplant Referral Form

Incomplete referrals will NOT be accepted Referral Date: (MMM/DD/YYYY): _____

Patient Contact Information	
Last Name First Name	Address
❑ Male ❑ Female ❑ Other	City Province Postal Code
Birth Date (MMM/DD/YYYY) _____	Email address (if available)
BC PHN:	Home Phone ( )
Height: _____cm Weight: _____kg BMI: _____	Cell Phone ( )
◯ English speaker ◯ Translator needed? If yes, specify language _____	
Caregiver/Support Person Name:	Home Phone ( )
Relationship to Patient:	Cell Phone ( )
Referring Specialist MSP #	**Family Physician** MSP #
Last Name First Name	Last Name First Name

Indication for Lung Transplant Assessment:

- ❑ Interstitial lung disease
- ❑ Obstructive lung disease
- ❑ Pulmonary hypertension
- ❑ Cystic fibrosis
- ❑ Congenital heart disease
- ❑ Other _____

Secondary Diagnosis:

1. _____
2. _____
3. _____

Cardiac Risk Factors:

- ❑ Hypertension ❑ Diabetes
- ❑ History of coronary artery disease
- ❑ Hyperlipidemia

To be Submitted with Referral Form:

MANDATORY REPORTS

- ❑ Medical summary of current illness
- ❑ CT chest (within 6 months)
- ❑ Detailed pulmonary function tests (within 6 months)
- ❑ 6 minute walk test (within 6 months)

CONDITION-SPECIFIC REPORTS *(mandatory):*

- ❑ Cystic fibrosis – sputum cultures with sensitivities
- ❑ Pulmonary hypertension – heart cath, echocardiogram
- ❑ Scleroderma – esophageal study (24 hour pH, manometry and impedence). If not done, refer to Dr. S. Dong (phone: 604.875.0333).

- ❑ Quit smoking (date): _____ Pack years: _____
- ❑ Attended pulmonary rehab Completion Date: _____

Office Use Only		
❑ Referral package complete Date: _____		❑ Referral criteria met ❑ Yes ◯ Urgent ◯ Standard ❑ No, advised referring specialist
Reviewed by	RN:	Doctor:
Review date:	(MMM/DD/YYYY): _____	(MMM/DD/YYYY): _____
Appt Date (MMM/DD/YYYY): _____		❑ Arranged for Translation Services
◯ Single Lung ◯ Double Lung ◯ Heart/Lung		

Your referral will be reviewed and triaged within 2 weeks by the transplant team. We will contact your patient directly to book an appointment.