Vancouver CoastalHealth
Promoting wellness. Ensuring care.

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

Fax: 604.642.8814
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 | Middle Name

Address

City | Province | Postal Code

Birth Date (MMM/DD/YYYY) ______________________* | Gender ❑ Male ❑ Female ❑ Other

BC PHN: | Home Phone: | Cell Phone:

❑ English speaker ❑ Translator needed? If yes, specify language ______________________________

Primary Caregiver/Support Person Name: | Relationship to Patient:

Home phone: | Cell Phone:

Referring Specialist MSP#_____________

Name: ___________________________

Signature: ________________________ **Date:** ___________

Family Physician MSP# ________

Name: ____________________________

Indication for Lung Transplant Assessment:

Primary Diagnosis: __________________________

Secondary Diagnosis: ________________________

Smoking history*:
-cigarette/tobacco: ❑Yes ❑No Stop date: _________
-marijuana: ❑Yes ❑No Stop date: _________
-vaping: ❑Yes ❑No Stop date: _________

Oxygen at home: ❑Yes ❑No
-rate at rest: _______ -rate on exertion: _________

Date of **Pulmonary rehabilitation** completion:____________

Height:____cm **Weight**:____kg **BMI**: ______*

***extreme BMI >35 or <15, age > 70, active smoking or smoking cessation < 6 months are general contra-indications.*

Please contact us if you have questions, urgent or exceptional referral:
-Pre Lung Transplant coordinator: **604-875-5182**

To be Submitted with Referral Form:

MANDATORY information
❑ Medical summary of current illness
❑ Medication list
❑ CT chest (within 6 months)
❑ ECHOcardiogram for >50 y-o
❑ Detailed pulmonary function tests (within 6 months)[1]
❑ 6 minute walk test (within 6 months)[1]

[1]attach PFT and 6MWT for last 2 years

❑ COVID-19 vaccination date of most recent:
____

CONDITION-SPECIFIC REPORTS *(mandatory):*
❑ Cystic fibrosis – sputum cultures with sensitivities
❑ Pulmonary hypertension – heart cath, echocardiogram

Office Use Only

❑ Referral package complete Date: ______________
❑ Referral package incomplete Date returned to ref. specialist: ____________

❑ Referral criteria met
❑ Yes ❍Urgent ❍ Standard
❑ No, advised referring specialist

Review by: Review date:	RN: (MMM/DD/YYYY):	MD: (MMM/DD/YYYY):

Appt Date (MMM/DD/YYYY): ______________________________ | ❑ Arranged for Translation Services

❑ *Your referral has been received by the lung transplant program and is pending review.*

❑ *Your referral has been reviewed by the transplant team. Your patient will be seen in approximately ___ weeks/ months and will be contacted directly. Please contact us 604-875-5182 if you believe the referral needs to be expedited.*