BAPTIST HEALTH HEART TRANSPLANT
AND
MECHANICAL CIRCULATORY SUPPORT PROGRAM

9500 Kanis Road, 4th Floor, Suite 410
Little Rock, Arkansas 72205
Phone: (501)202-1500, Option 2 **Fax :(501)202-1133** **Toll Free: 1-800-768-8003**

From: _____ **Date:** _____

Referring Physician **Clinic Name**

Address **City** **State** **Zip**

Phone **Fax**

Type of Referral: (please circle)
Transplant Evaluation Destination Therapy Advanced CHF Management

Patient Information

First **Middle** **Last**

Address **City** **State** **Zip**

SEX: M F **RACE:** W B O

Please indicate preferred contact number: **Type**

Alternate 1# _____ _____
Alternate 2# _____ _____
Alternate 3# _____ _____
SS#: _____ **DOB**: _____

Please select if applies:
G Cannot read or write
G Blind
G Compliance Issues
G Deaf
G Does not speak English
G Tobacco/Substance Abuse
G Other _____
_____

INSURANCE
Primary _____
Secondary _____

Information that MUST be provided with this referral: Patient cannot be scheduled for a transplant evaluation at Baptist Transplant until all information is received. Thank you for your cooperation in this matter.

- ☐ Most current clinic note
- ☐ History & Physical or Discharge Summary
- ☐ Lab flow sheet showing last 3 sets of labs
- ☐ Current medications list
- ☐ Height and weight AND BMI
- ☐ Copy of patient's insurance cards (front and back)
- ☐ Copy of patient's ICD pacemaker card (front and back)
- ☐ Most recent Echocardiogram Report
- ☐ Most recent Heart Catheterization Report (LHC, RHC or both)

*Please provide either DVD/Tape/Disc