LUNG TRANSPLANT REFERRAL PROFORMA

Patient name - 
Sex - 
DOB - 
Weight - 
Occupation - 
Address -

Date -
Age -
Height -
Blood group -

Phone -
Email -
Referring physician/Hospital -
Physician’s Contact number -
Primary respiratory/lung diagnosis -
Month/Year when diagnosis made -

Lung biopsies  yes  no

Is the patient on home oxygen?  yes  no

Oxygen needed for more than 15hrs/day?  yes  no

How much oxygen does the patient need at rest?

Is the patient bed bound for more than 75% of the day?

Can he/she walk to the bathroom?

Does he/she need help with bathing, dressing and eating?

Can he/she walk for 6 minutes without stopping?

Any history of:

Stroke  yes  no
Heart disease  yes  no
Kidney disease  yes  no
Liver disease  yes  no
Diabetes  yes  no
Cancer  yes  no
Tuberculosis  yes  no  ________________________________
Pneumothorax  yes  no  ________________________________
Chest surgeries  yes  no  ________________________________
ICU admissions  yes  no  ________________________________
Ventilator support  yes  no  ________________________________
Hospitalizations in the last 6 months  yes  no  ________________________________
Current Smoker  yes  no  ________________________________

How many years of smoking?
When did the patient stop smoking?

Other medical history –

Current medications:
Is the patient currently on steroids?  yes  no

Date commenced on steroids –
Date stopped –
Current dose –
Maximum dose –
Other medications –

1. Six minute walk test. Date last performed –
   Distance walked –

2. Pulmonary function testing. Date last performed –
   FEV1 -  FVC -  TLC -  DLCO –

3. Arterial blood gas. Date last performed –
   pH -  pO2 -  pCO2 -  HCO3 -

4. Blood investigation. Date last performed -
   Hb -  wbc -  platelet -  Sodium -  Potassium -
   Urea -  Creatinine -

Please attach reports of the following tests if available – PFT, 6min walk test, ABG, ECG, Echocardiogram, Chest Xray, CT chest, Coronary angiogram, DEXA scan, Endoscopy and Right Heart Catheterization.