LUNG TRANSPLANT REFERRAL INSTRUCTIONS

Thank you for your interest in the Lung Transplant Program at Cedars-Sinai Medical Center.

Please complete the attached form and return with the following records listed below. Once all records have been obtained and reviewed, we will contact the patient with appointment details.

REQUIRED PATIENT RECORDS:

- ☐ **Insurance Cards – Clear Copy of Front and Back**
- ☐ **Personal Identification (Photo ID) – Driver's License or Other**
- ☐ **Recent History & Physical (H&P)**
- ☐ **Pulmonary Function Test (Done within 3 months)**
- ☐ **6 Minute Walk Test (Done within 3 months)**
- ☐ **Chest CT Report and Imaging Disk (Done within 12 months)**
- ☐ **Echocardiogram Report and Imaging Disc (Done within 6 months)**
- ☐ **Chest X-Ray Report and Imaging Disk (Done within 6 months)**

REQUESTED PATIENT RECORDS (IF COMPLETED):

- ☐ **Lung Biopsy/Surgery Reports**
- ☐ **Consultant Notes (Cardiology, Nephrology, or Rheumatology)**
- ☐ **Enrollment in Pulmonary Rehabilitation Program**
- ☐ **Recent Laboratory Studies**
- ☐ **Arterial Blood Gases**

SEND RECORDS TO:

(Preferred) Email: LungTransplantReferral@cshs.org

Mail: Lung Transplant Program
8900 Beverly Blvd. 2nd Floor
Los Angeles, CA 90048

Fax: (310) 423-5666
Phone: (310) 423-7249

Please contact Anna Puhky, RN with any questions or concerns,

Phone: (310) 967-7024 / **Email:** Anna.puhky@cshs.org

Transplant Pulmonologists
Reinaldo Rampolla, MD, Medical Director
Jeremy Falk, MD
Lorenzo Zaffiri, MD

Transplant Surgeons
Dominick Megna, MD, Surgical Director
Pedro Catarino, MD
Dominic Emerson, MD

Director, HLA Laboratory
Xiaohai Zhang, PhD

AssociateDirector
Maria Fe White, ACNP/FNP-BC

Clinical Program Manager
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Referral Transplant Coordinators
Krystal Guevara, RN
Pre- Transplant Coordinator
Jody Kieler, RN
In-patient Coordinator
Joshua Rhoades, RN
Post-Transplant Coordinators
Saira Angeles, RN
Karen Lemberger, RN
Andre Lee, RN

Transplant Nurse Practitioners
Heidi Woo, NP
Katherine Wilhelm, NP
Leira Marte, NP
Mauna Desai, NP

Patient Service Representatives
Glenda Andrade Dietra
Torres Marissa Vasquez

Pharmacist
Darina Barnes, Pharm.D.

Dietitian
Patricia Martin, RD

Social Workers
Marshia Caceres, LCSW
Monica Hour, LCSW

Finance Team
Carla McMillan, Associate Director
Karina Solorzano
Emily Dinh

LUNG TRANSPLANT REFERRAL FORM

Name:	Social Security Number:	Date of Birth:
Mailing Address:	City / State / Zip:	
Home Phone: Cell Phone:	Emergency Contact / Telephone:	
Email Address:		

Insurance	Subscriber	Policy #	Group #	Eff. Date

Primary MD:	Primary MD Phone #:	Fax #:
Referring MD:	Referring MD Phone #:	Fax #:

Please indicate medical reason for referral:

- ☐ **Lung Transplant**
- ☐ **Heart-Lung Transplant**

The patient will be seen by the earliest appointment available.