Heart Transplant
Physician Referral Form

UCDAVIS HEALTH | Transplant Center

Inpatient transfer request? Yes ◯ No ◯

If this is an urgent consultation, please call **1-916-734-2111**

Please fill out this form completely, include any clinical documentation relevant to this referral, and fax all documents to **1 (916) 734-5194** Mail additional imaging CDs and/or documentation to: UC Davis Transplant Center, 2315 Stockton Blvd, Housestaff Bldg, Sacramento, CA 95817. To speak with a heart transplant coordinator, call **1 (916) 734-2111**.

◯ **Clinical Documentation**
H+P, cardiac cath or myocardial perfusion scan, and echocardiogram are required. Please also send other relevant records if available.

Patient Information:

First Name: | Middle Name: | Last Name:

Gender: | Date of Birth (mm/dd.yyyy): | Height: | Weight:

Primary Phone: | Email: | Primary Insurance: | Secondary Insurance:

Street Address:

City: | State: | Zip: | Country:

Details:

Reasons for Referral:

Preferred Physician or Provider Name if Applicable:

Department or Specialty Area:

◯ Consult or Second Opinion ◯ Transfer of Care

Referring Provider Information:

Provider First Name: | Provider Last Name:

Provider Title: | Cell Number (optional):

Street Address: | City: | State:

Zip: | Phone: | Extension: | Fax:

Physician Signature:_____ Date: _____