Transplant Patient Referral Form:

☐ Liver ☐ Heart ☐ Kidney
☐ Intestinal and MV ☐ Lung ☐ Pancreas and Kidney-Pancreas
☐ VAD ☐ Heart-Lung ☐ Urology
☐ Other: ____________________

Patient Status: ☐ Inpatient ☐ Outpatient

Patient Name: ____ DOB (mm/dd/yyyy): ____/____/________
First MI Last

Diagnosis (ICD9/10): ____________________________________ Sex: ________ Height: ________ Weight: ____________

SSN: _________-________-____________ Citizenship: ☐ U.S. ☐ Resident Alien ☐ Non-Resident Alien

Home Phone #: (_____) _______ - __________ Cell Phone #: (_____) _______ - _________ Work Phone #: (_____) _______ - ____________

Address: ____

City: ___________________________ State: ____________ Zip: ___________ County: ______________ Country: ________________

Additional Contact Information (E-mail):____

Emergency Contact (Name): ____ Emergency Contact (Telephone): (_____) _______ - __________

Referring Physician: ____ Medical Specialty: ____

Referring NPI: ____ Referring Email Address: ____________________________________

Referring Facility Contact: ______________________________________ Phone #: (____) ______ - ________ Fax #: (____) ______ - ________

Group Name (if applicable): ____________________________________ Address: ____

City: ___________________________ State: ____________ Zip: ___________ County: ______________ Country: ________________

PRIMARY INSURANCE INFORMATION: (Please provide a copy of the front and back of card)

Insurance Company Name: ______________________________________ Policy #: ___________________________ Group #: ____________

Insurance Subscriber: ____ DOB of Subscriber (mm/dd/yyyy): ______/_______/____________

Relationship to Patient: __________________________ Has the insurance company been notified of referral? ☐ Yes ☐ No

Primary Care Physician: ____________________________________ Phone #: (____) ______ - ________ Fax #: (____) ______ - ________

SECONDARY INSURANCE INFORMATION: (Please provide a copy of the front and back of card)

Insurance Company Name: ______________________________________ Policy #: ___________________________ Group #: ____________

Insurance Subscriber: ____ DOB of Subscriber (mm/dd/yyyy): ______/_______/____________

Relationship to Patient: __________________________ Has the insurance company been notified of referral? ☐ Yes ☐ No

MTI
Received by: ____________ Date:____/____/___

1801 N.W. 9th Avenue
Miami, FL 33136

For questions call: 305-355-1MTI (1684)
Fax Referral Form & Medical Records: 305-355-5368

MTIReferral@jhsmiami.org
www.MiamiTransplant.org