Children's of Alabama

Heart Transplant Referral Form

Address: 1600 7th Avenue S
Birmingham, AL 35233
Phone: (205) 638.6631
Fax: (205) 638.2319

Reason for referral & diagnosis:

Patient demographics

Name: _____

Adress: _____

City: _____

Social Security Number: _____ - _____ - _____

Phone: _____

Emergency Contact: _____

Primary Language: _____

Child's preferred name: _____

State: _____ Zip: _____

DOB: _____ Gender: _____ Race: _____

Parent/Guardian Name: _____

Parent/Guardian email: _____

Phone: _____ Relationship: _____

Interpreter needed: YES ☐ | NO ☐

Physician Information

Referring Physician & NPI: _____

Practice/Group Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Person completing Form: _____

Primary Care Physician & NPI: _____

Practice/Group Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Primary Insurance Information

Company: _____

Policyholder's Name: _____

Policy ID: _____ Group Number: _____

Policyholder's DOB: _____

Referral or Pre-Cert Number: _____

Secondary Insurance Information

Company: _____

Policyholder's Name: _____

Policy ID: _____ Group Number: _____

Policyholder's DOB: _____

Referral or Pre-Cert Number: _____

Patient General Clinical Information

Has your child ever been seen at Children's of Alabama? YES ☐ | NO ☐ If yes, date of last visit:

List of hospitals the child has previously received care:

Clinical Information Requested to Schedule Appointment

1. Most recent clinical summary and current medications, treatment plans, and past medical history or typed consult letter, including patient's clinical summary and pertinent medical history
2. Most recent labs results
3. Most recent imaging results
4. Procedural reports, including operative notes
5. Requests images via disc or electronically

PLEASE FAX COMPLETED FORM TO HEART TRANSPLANT AT: (205) 638-3689