REFERRAL FAX

Referral for cardiac transplant:

Name:

DOB:

Date: _____

Referring MD: _____

pages, including cover sheet: _____

To: Saint Luke's Hospital
Mid America Heart Institute
4401 Wornall Road
Kansas City, MO 64111

Attn: _____

Phone: 816-932-3264

Fax: 816-932-5645

From: _____
_____
_____

Phone: _____

Fax: _____

Information Attached:

___ Demographic page, include insurance information
___ Recent history & physical
___ Echocardiogram
* If possible, send films with patient or mail
___ Catheterization
* If possible, send films with patient or mail
___ Lab
___ Any other pertinent information

Comments:

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message by error, please notify us immediately and destroy the related message.