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Healthcare savings and satisfaction through innovation and respect.

Please complete and FAX this questionnaire with the following clinical information to 503-654-8570:

Submitted By: ______________________________Phone: ______________________Fax: __________________

Patient Name: ____ DOB: ______________________

Employer/Plan Name: _______________________________ Plan ID: ______________

Please indicate the ***date of service*** for this pending request: ___________________ or ❑ Not Scheduled

Facility:____Phone:_______________________________

Facility Address:____

Physician:____Phone:_______________________Fax:_________________

Provider Address:____

Please identify the diagnosis and surgical procedure(s) requested:

ICD9 code(s): ____

CPT: __________________ Description: ____

CPT: __________________ Description: ____

CPT: __________________ Description: ____

For **Transplant Evaluation**:

- ☐ Medical records including physical exam and medical history
- ☐ Any applicable diagnostic imaging or lab results (e.g., CT Scan, MRI, Chest Xray, serologies, chemistries, etc.)

For **Transplant Surgery**:

- ☐ *Most recent* medical records including physical exam and medical history from transplant evaluation
- ☐ Evaluation of major organ systems if applicable
- ☐ *Most recent* laboratory assessment, including serologies, (e.g. HIV, hepatitis, CMV etc.)
- ☐ *Most recent* applicable diagnostic imaging results (i.e., CT Scan, MRI, Chest Xray)
- ☐ Dental Evaluation if available
- ☐ Psychosocial Evaluation
- ☐ Age appropriate cancer screening results (i.e., colonoscopy, pap smear, mammogram, prostate test, etc)

Is this transplant (or any portion) part of a ***clinical trial***? ____ yes ____no ____N/A

If yes, please attach clinical trial protocol.