**Lung Candidate Summary**

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| Single | [ ]  | Double | [ ]  | Single or Double | [ ]  |

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| **OSOTC Patient Number:** |       |

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| **PATIENT DEMOGRAPHICS** |
| **Initials:**       | **Birth Date:**       | **Height:**       |  **Weight:**       |  |
| **Gender:** M [ ]  F [ ]  | **ABO:** A [ ]  B [ ]  AB [ ]  O [ ]  | **Race:**       | **Transplant#:**       |  |

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| **PATIENT STATUS** |
| **MEDICAL DIAGNOSIS:**       |  |
| **MEDICAL HISTORY** (Please indicate nutritional status, infection, ascites, variceal hemorrhage, encephalopathy, etc.):      |

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| **Laboratory Data** |
| **Renal** | Patient | Lab Date |  |
| BUN |       |       |  |
| Creatinine |       |       |  |
| **Hepatic** | Patient | Lab Date |  |
| AST (SGOT) |       |       |  |
| ALT (SGPT |       |       |  |
| Alk Phos |       |       |  |

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| **Cardiac Catheterization** |
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| **2D Cardiac ECHO** |
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| **Electrocardiogram** |
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| **Pulmonary Function Test** |
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| **6 Minute Walk Test** |
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| **Quantitative Perfusion Scan** |
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| **CT Chest** |
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| **Cancer Screenings** (PSA, colonoscopy, mammogram, pap) |
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| **Smoking History & Length of Abstinence** |
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| **Psychosocial Evaluation/Quality of Life**(Support system, informed consent, attitude about transplant, aftercare, complications, etc.): |
|       |

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| **Ohio Medicaid Insurance**The Ohio Medicaid Required Information Form should be submitted along with this summary. |
| **Select Type:**  | Standard Medicaid [ ]   | Medicaid Managed Care Plan [ ]   |