**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 |