Duke Lung Transplant Program

**Time to Transplant**
Shorter wait time than national median

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<th>Duke</th>
<th>U.S.</th>
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<td>15 days</td>
<td>61 days</td>
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* Data from srtr.org as of 7/6/23 for median wait time for transplant.

**Transplant Volumes**

- **#1 program** by total volume and **#2** in 2022 volume in the U.S.**

**Transplant Evaluation Options**

- **1 day**
  - One-day consultation
- **2 days**
  - Two-day limited evaluation
- **5 days**
  - Five-day full evaluation

Out of State Pre-and Post Lung Transplant Video Visits Available

**Overview**

The Duke Lung Transplant Program is among the most established and successful in the world.

Since 1992, our lung transplant surgeons have performed more than 2,400 lung transplants.

Our experienced team understands all aspects of lung transplant care and is here to help you care for your patients.

**When to Refer**

You can refer your patients to us when they have the following signs and symptoms for diseases, including:

- **Chronic Obstructive Pulmonary Disease**
  - FEV1 <40% and/or DLCO <30%
  - Oxygen dependence
  - Hypercarbia
  - Frequent exacerbations
  - Persistent, activity-limiting symptoms in spite of rehabilitation

- **Cystic Fibrosis and Bronchiectasis**
  - Increasing frequency of exacerbations
  - Progressive decline in lung function, requiring ICU care
  - Oxygen dependence
  - Hypercarbia
  - Secondary pulmonary hypertension
  - FEV1<40%
  - Recurrent or refractory pneumothorax

- **Interstitial Lung Disease (ILD)**

- **Pulmonary Arterial Hypertension**

- **Sarcoidosis**
  - FEV1 <50% and/or DLCO <40%
  - Oxygen dependence
  - Hypercarbia
  - Secondary pulmonary hypertension

- **Other Lung Diseases**
  - when there is hypoxia, hypercarbia, or disease progression despite medical therapy

To make a referral, log in to Duke MedLink or call 919-613-7777
Your Patients Will Have Access To:

Lung Transplant Specialists

Our surgeons have special expertise in performing lung transplants and offer:

- Management of the full spectrum of lung transplant care
- Individualized patient assessment
- Comprehensive pulmonary rehab and education programs
- Excellent outcomes in multi-organ transplants, including combined heart and lung transplants

Clinical Trials

We screen every patient for clinical trial eligibility to give your patients access to novel therapies as part of our pioneering clinical, basic, and translational research.

Qualified Donors

We offer deceased lung transplantation and participate in national registries for benchmarking quality.

Our Care Team Members

Cardiothoracic Surgeons
Matthew G. Hartwig, MD
  Surgical Director
Jacob A. Klapper, MD
  Associate Surgical Director
Kunal Patel, MD
Hai Salfity, MD

Pulmonologists
John M. Reynolds, MD
  Medical Director
Scott M. Palmer Jr., MD
  Scientific Director
Laurie D. Snyder, MD
  Associate Medical Director
Hakim Azfar Ali, MD
Alexander Graham, MD
Brandon Menachem MD
Lake D. Morrison, MD
Matthew Pipeling, MD
Jamie L. Todd, MD
Jordan Whitson, MD
Katherine Young, MD

Find the most up-to-date list of providers at DukeHealth.org/Transplant

Location

Duke Clinic 2F/2G
40 Duke Medicine Cir.
Durham, NC 27710

Phone 919-613-7777
Fax 919-681-5770
Toll-free 800-249-5864

On-call Physician 919-684-8111
Email lungtran@dm.duke.edu
Duke Lung Transplant Referral Form

Please fax the completed referral form to 919-681-5770 or use electronic referral through Epic / MedLink. Once received, a scheduler will contact your patient to schedule an appointment. We appreciate your referral.

Patient Demographic Information

Name:__________________________ Address:______________________________
City:________________________ State:________________________ Zip:______________
Date of Birth:__________________ Gender:________________________ Race:__________
Primary Phone:________________ Alternative Phone:____________________
E-mail:________________________
Emergency Contact:____________ Phone:________________________ Relationship:________
Does Patient Need an Interpreter? Y N Language:________________________

Physician Information

Referring Physician:________________________ Primary Care Physician:________________________
Practice/Group Name:________________________ Practice/Group Name:________________________
Address:____________________________ Address:____________________________
City:________________________ State:________________________ Zip:______________
Office Phone:________________________ Office Phone:________________________
Office Fax:________________________
Referring Physician Cell Phone:________________________ Referring Physician E-mail:________________________
Name of Person Completing This Form:________________________ E-mail:________________________
Communication Preference: Email [] Fax [] Epic [] Medlink []

Primary Insurance Information (attach copy of both sides of card)

Company:________________________ Policy ID:________________________ Group Number:________________________
Policyholder’s Name:________________________ Referral or Pre-Cert Number:________________________
Insurance Phone Number:________________________ Policyholder’s DOB:________________________
Behavioral Health Insurance? Y N Company:________________________ Policy ID:________________________

Secondary Insurance Information (attach copy of both sides of card)

Company:________________________ Policy ID:________________________ Group Number:________________________
Policyholder’s Name:________________________
Insurance Phone Number:________________________ Referral or Pre-Cert Number:________________________

Patient General Clinical Information

Seen at Duke University Hospital? Yes No If yes, date of last visit: _____________ Duke Medical Record Number: _____________
Primary Lung Diagnosis:________________________
Patient Height:________________________ Patient Weight:________________________ Date of Measurements:________________________
Currently Smoking Tobacco Products? Y N Current Using Other Tobacco or Nicotine Products? Y N
How Much Oxygen Use at Rest:___________ (L/min) How Much Oxygen Use at Exertion:___________ (L/min)
Smoking Cessation Date, if applicable:________________________
Other Tobacco/Nicotine Cessation Date, if applicable:________________________

Required Medical Records (Please send what is available even if incomplete)

- Recent clinic notes including list of current medications
- Arterial blood gas and pulmonary function test (PFT) results from the last 12 months
- Copies of both sides of all medical insurance cards- primary and secondary
- Recent chest x-ray/CT reports
- Recent labs tests, including complete blood count and comprehensive metabolic panel
- Reports of any cardiology studies, including heart catheterization, echo, and stress test
- Operative reports and esophageal studies in the last six months, if applicable
- Recent inpatient records, if applicable
- Nutrition Summary and last note, if applicable