

Cardio-Thoracic Surgery Clinic

Fax: 504.903.2149

Referral from: BMC EKL LJC LAK
 LIH UMC WOM Other: _____

Patient Label/Stamp

Attending Provider: _____ ID Number: _____

If Patient Label/Stamp is Not Available Complete the Following:

Patient's Name: _____ Date of Referral: ___/___/___

Date of Birth: ___/___/___ Medical Record Number: _____

1° Contact Number: _____ 2° Contact Number: _____

Email Address: _____

Reason for Referral & Workup needed prior to appointment: See abbreviations and notes below (1)

- ___ 441 Aortic/Thoracic Aneurysm: CT Angiogram (2), Cardiac Stress Test, TTE, and PFTWRAABG
- ___ 424.1 Aortic Valve Disease: Cardiac Catheterization, TTE, and PFTWRAABG
- ___ 745.5 Atrial Septal Defect: Cardiac Catheterization if age < 45
- ___ 414.0 CAD/CABG evaluation: Cardiac Catheterization (within 8 months), Carotid U/S, TTE, ABI, PFTWRAABG

- ___ 433.1 Carotid Stenosis: MRA or Carotid Angiogram
- ___ 150.9 Esophageal Cancer: CT Abd & Chest (2), Cardiac Stress Test, and PFTWRAABG
- ___ 530.3 Esophageal Stricture/Achalasia: Barium Esophagram, Esophagomanometry
- ___ 162.9 Lung Mass/Nodule: CT Scan of Chest (2), PFT/RAABG
- ___ 164.9 Mediastinal Mass: CT Scan of Chest (2)
- ___ 394.9 Mitral Valve Disease: Cardiac Catheterization, TTE, and PFTWRAABG
- ___ 423.9 Pericardial Disease: TTE
- ___ 511.9 Pleural Effusion/Empyema: CT Scan of Chest (2)
- ___ V58.49 Post Operative Care
- ___ 424.2 Tricuspid Disease: TTE; PFTWRAABG
- ___ Other ICD 9: ___ Diagnosis: _____

(1)Abbreviations: TTE = Trans-Thoracic Echocardiogram; PFTWRAABG = Pulmonary Function Test with Room Air Arterial Blood Gas; ABI = Ankle-Brachial Index

(2)Note: All MRI & CT Scan studies require contrast, which also requires documentation of current BUN/ Creatinine or GFR within 30 days of the performance of the study. (Metformin/Glucophage may be taken on the morning of the study but must be held for 48 hours & repeat renal function evaluation must be performed prior to resumption.)**

Clinical History Relevant to this Referral: _____

Referring Provider's Signature: _____ ID Number: _____

Contact Number: _____ Referring Service/Clinic: _____

OFFICE USE ONLY: Appointment Date: ___/___/___ Time: ___:___ am/pm.

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

Rev 02/19/09