LSU Health System
Interim LSU Hospital in New Orleans

Cardiology Clinic

Fax 504.903.2149

Patient Label/Stamp

Referral from: __BMC __EKL __LJC __LAK
__LIH __UMC __WOM __Other: ____________

Attending Provider: ________________ ID Number: ____________

If 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: ____

Please Indicate Reason for Referral:

___746.9 Adult Congenital Heart Disease
___427.9 Arrhythmia
___425 Cardiomyopathy
___786.59 Chest Pain
___440.21 Claudication
___414.0 Coronary Artery Disease previously diagnosed (or previous MI)
___428.0 Heart Failure
___402 Hypertensive Heart Disease
___785.1 Palpitations
___443.9 Peripheral Vascular Disease
___440.1 Renal Artery Stenosis
___780.2 Syncope
___429.9 Valvular Heart Disease
___Other ICD 9:______ Diagnosis:____

Obtain EKG, CBC, CMP, & Urinalysis for all Cardiology referrals if not already done.
Have the patient bring copies of any lab work, EKG and medical records not available at MCL.

Clinical History Relevant to this Referral: ____
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Referring Provider's Signature: ____________________________ ID Number: __ __ __ __ __
Contact Number: __ __ __-__ __ __-__ __ __ __ Referring Service/Clinic: _______________
Fax Number: __ __ __ - __ __ __ - __ __ __ __ Email: _______________________________

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