LSU Health System
Interim LSU Hospital in New Orleans

Patient Label/Stamp

Dental Clinic

Fax: 504.903.3479

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

Attending Provider: _________________ **ID Number:** ____________

If Patient Label/Stamp is Not Available, Please Complete the Following:
Patient's Name: ____ **Date of Referral:** ____/____/____
Date of Birth: ______/______/______ **Medical Record Number:** _________________________________

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1˚ Contact Number: _________________________ **2˚ Contact Number:** _________________________
Email Address: ____

1. Indicate Priority: ___urgent ___routine

2. Select Reason for Referral:

___521.00 Dental Caries
___V72.83 Dental Pre-op Clearance for: _______________________ (medical/surgical procedures)
___523.4 Gum Disease

3. Please indicate patient's functional health status:

___P1: **Normal healthy patient** (heart, lungs, liver, kidneys, and CNS are within normal limits)
___P2: **Mild systemic disease** (able to walk up one flight of stairs or walk two level city blocks but must rest at the completion of the task because of distress—chest pain, undue fatigue, or shortness of breath)
___P3: **Severe systemic disease** (able to walk up a flight of stairs or walk two level city blocks but must stop [at least once] ***before reaching their goal*** because of distress)
___P4: **Severe systemic disease that is a constant threat to life** (unable either to walk up a flight of stairs or walk two level city blocks)

Clinical History Relevant to this referral: ____
____
____
____

*****Indicate co-morbid conditions for this patient:**

___Anticoagulation Therapy ____Bisphosphonate Therapy ___Cancer
___Cardiac Disease ____Lung Disease ___Morbid Obesity
___Recent (< 6 months) MI or CVA ____Sickle Cell Disease ____Uncontrolled Diabetes
___Other:____

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 2/19/09

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