

Dermatology Clinic

Fax: 504.903.1605

Patient Label/Stamp

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

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: _____

Please Indicate Reason for Referral:

- | | |
|---|--|
| <input type="checkbox"/> 706.8 Asteatosis, Eczema | <input type="checkbox"/> 709.09 Melasma |
| <input type="checkbox"/> 691.8 Atopic Dermatitis | <input type="checkbox"/> 216.9 Moles (Dysplastic Nevi) |
| <input type="checkbox"/> 706.1 Acne, Failed Medical Therapy | <input type="checkbox"/> 078.0 Molluscum contagiosum |
| <input type="checkbox"/> 702.0 Actinic (solar) keratosis | <input type="checkbox"/> 238.2 Neoplasm, uncertain behavior |
| <input type="checkbox"/> 704.00 Alopecia | <input type="checkbox"/> 703.9 Nail Disorder or infection |
| <input type="checkbox"/> 173.9 Carcinoma, Skin | <input type="checkbox"/> 110.1 Onychomycosis |
| <input type="checkbox"/> 078.11 Condyloma Acuminatum | <input type="checkbox"/> 132.9 Pediculosis |
| <input type="checkbox"/> 706.2 Cyst, Epidermal | <input type="checkbox"/> 696.3 Pityriasis Rosea |
| <input type="checkbox"/> 709.9 Dermatitis & seborrheic dermatitis | <input type="checkbox"/> 698.9 Pruritus |
| <input type="checkbox"/> 693.0 Drug Reaction | <input type="checkbox"/> 704.8 Pseudofolliculitis barbae |
| <input type="checkbox"/> 692.9 Eczema, Failed Medical Therapy | <input type="checkbox"/> 696.1 Psoriasis |
| <input type="checkbox"/> 707.9 Extremity ulcerations | <input type="checkbox"/> 287.2 Purpura |
| <input type="checkbox"/> 704.8 Folliculitis, Failed Medical Therapy | <input type="checkbox"/> 686.00 Pyoderma, abscess, furuncle |
| <input type="checkbox"/> 054.9 Herpes simplex | <input type="checkbox"/> 782.1 Rash or other skin eruptions |
| <input type="checkbox"/> 053.9 Herpes zoster | <input type="checkbox"/> 133.0 Scabies |
| <input type="checkbox"/> 705.83 Hidradenitis | <input type="checkbox"/> 710.1 Scleroderma, systemic |
| <input type="checkbox"/> 684 Impetigo | <input type="checkbox"/> 709.9 Skin lesion cancer evaluation |
| <input type="checkbox"/> 703.0 Ingrown Toenail | <input type="checkbox"/> 110.9 Tinea (fungus) |
| <input type="checkbox"/> 701.4 Keloid | <input type="checkbox"/> 708.9 Urticaria |
| <input type="checkbox"/> 697.0 Lichen planus | <input type="checkbox"/> 287.0 Vasculitis, cutaneous |
| <input type="checkbox"/> 695.4 Lupus Erythematosus, Discoid | <input type="checkbox"/> 057.9 Viral Exanthem |
| <input type="checkbox"/> 710.0 Lupus Erythematosus, Systemic | <input type="checkbox"/> 709.01 Vitiligo |
| <input type="checkbox"/> 172.9 Melanoma | <input type="checkbox"/> 078.10 Wart(s) |

Other ICD: _____ Diagnosis: _____

Clinical History Relevant to this Referral: _____

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