

Patient Label/Stamp

General Surgery Clinic

Fax: 504.903.1605

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: _____

Please Indicate Reason for Referral:

- | | | | |
|---------------------------------|--|--|-----------------------------|
| <input type="checkbox"/> 793.99 | Abnormal imaging studies:
Describe in Clinical History*** | <input type="checkbox"/> 996.92 | Infected Hickman Catheter |
| <input type="checkbox"/> 565 | Ano-rectal Fissure & Fistula | <input type="checkbox"/> 214.9 | Lipoma |
| <input type="checkbox"/> 455.6 | Ano-rectal: Hemorrhoids | <input type="checkbox"/> 785.6 | Lymphadenopathy |
| <input type="checkbox"/> 569.42 | Ano-rectal: Pain | <input type="checkbox"/> 153.9 | Malignancy: Colon |
| <input type="checkbox"/> 566 | Ano-rectal: Peri-rectal Abscess | <input type="checkbox"/> 151.9 | Malignancy: Gastric |
| <input type="checkbox"/> 685.0 | Ano-rectal: Pilonidal Disease | <input type="checkbox"/> 157.9 | Malignancy: Pancreas |
| <input type="checkbox"/> 078.10 | Ano-rectal: Warts | <input type="checkbox"/> 193 | Malignancy: Thyroid |
| <input type="checkbox"/> 949.0 | Burn: describe in Clinical History | <input type="checkbox"/> 789.30 | Mass: Abdomen |
| <input type="checkbox"/> 574.20 | Cholelithiasis | <input type="checkbox"/> 782.2 | Mass: Axilla |
| <input type="checkbox"/> 575.10 | Cholecystitis | <input type="checkbox"/> 569.9 | Mass: Back |
| <input type="checkbox"/> 562.11 | Colonic Diverticulitis | <input type="checkbox"/> 573.9 | Mass: Colon |
| <input type="checkbox"/> V16.0 | Familial Adenomatous Polyposis | <input type="checkbox"/> 786.6 | Mass: Liver |
| <input type="checkbox"/> 553.3 | Hernia: Diaphragmatic | <input type="checkbox"/> 246.9 | Mass: Lung |
| <input type="checkbox"/> 750.6 | Hernia: Hiatal | <input type="checkbox"/> 879.2 | Mass: Thyroid |
| <input type="checkbox"/> 553.21 | Hernia: Incisional | <input type="checkbox"/> 879.6 | Open Wound: Abdomen |
| <input type="checkbox"/> 550.9 | Hernia: Inguinal | <input type="checkbox"/> 894.0 | Open Wound: Trunk |
| <input type="checkbox"/> 553.1 | Hernia: Umbilical | <input type="checkbox"/> 884.0 | Open Wound: Lower Extremity |
| <input type="checkbox"/> 553.2 | Hernia: Ventral | <input type="checkbox"/> 240.9 | Open Wound: Upper Extremity |
| <input type="checkbox"/> 705.83 | Hidradenitis—referred from
Dermatology | <input type="checkbox"/> 241.0 | Thyroid: Goiter |
| | | <input type="checkbox"/> other: ICD: _____ | Thyroid: Nodule |

Clinical History Relevant to this Referral: _____

***Please send copies of Images & Reports from studies not available at MCL or in CLIQ.

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 09/16/09