

Hand 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 is Not Available Complete the Following:

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

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

Primary Contact Number: _____ Secondary Contact Number: _____

Email: _____

Please Indicate Reason for Referral:

- 354.0 Carpal Tunnel Syndrome (Please obtain EMG/NCV prior)
- 728.6 Dupuytren's contracture
- 727.41 Ganglion Cyst
- 718.44 Hand/ Finger Contracture
- 959.4 Hand Injury, except finger
- 199 Hand Tumor
- 955.9 Nerve Injury Hand or Forearm
- 714.0 Rheumatoid Arthritis
- 709.2 Scar contraction: evaluation for release procedure
- 727.89 Tendon Adhesions
- 727.05 Tenosynovitis (non-suppurative)
- 727.03 Trigger Finger
- Other _____

***Please page the Resident On Call for Hand Surgery at 504.903.3000 for 1) acute fractures of carpals, metacarpals, or phalanges, 2) lacerations of the finger, hand or forearm that involve tendon(s), or 3) suppurative tenosynovitis or other infections of the hand**

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 02/19/09