

### Hematology & Oncology Clinic

136 South Roman Street, New Orleans, LA 70112  
Phone: 504-903-0209 Fax: 504-903-0210

Patient Label/Stamp

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: \_\_\_\_\_

1° Contact Number: \_\_\_\_\_ 2° Contact Number: \_\_\_\_\_

Email: \_\_\_\_\_

#### Please Indicate Reason for Referral (and note needed workup):

- |   |  |
|---|--|
| <input type="checkbox"/> 286.9 Disorders of Coagulation: (1, 2) | <input type="checkbox"/> Malignancy (continued): |
| <input type="checkbox"/> 289.9 Leukemia: (1)                    | <input type="checkbox"/> 239.9 GI/GU: (5, 9)     |
| <input type="checkbox"/> 289.9 Lymphoma: (1)                    | <input type="checkbox"/> 172.9 Melanoma: (5)     |
| <input type="checkbox"/> 289.9 Pancytopenia: (1)                | (1) CBC, Platelet, Differential                  |
| <input type="checkbox"/> 203 Plasma Cell Dyscrasias: (1, 3)     | (2) PT, PTT, INR                                 |
| <input type="checkbox"/> 287.5 Disorders of Platelets: (1)      | (3) SPEP, UPEP, Beta-2 Microglobulin             |
| <input type="checkbox"/> 289.9 Disorders of RBC's: (1, 4)       | (4) Reticulocyte Count                           |
| <input type="checkbox"/> 288.9 Disorders of WBC's: (1)          | (5) Biopsy report                                |
| <input type="checkbox"/> Malignancy:                            | (6) CT Scan Head & Neck with contrast            |
| <input type="checkbox"/> 149 Head & Neck: (5, 6)                | (7) CT Scan of affected area with contrast       |
| <input type="checkbox"/> 170 Bone: (5, 7)                       | (8) CT Scan Chest & Abdomen with contrast        |
| <input type="checkbox"/> 174.9 Breast: (5)                      | (9) CT Scan Abdomen & Pelvis with contrast       |
| <input type="checkbox"/> 239.1 Chest: (5, 8)                    |  |
| <input type="checkbox"/> Other: ICD: _____ Diagnosis: _____     |  |

Clinical History Relevant to this Referral: \_\_\_\_\_

Previous Radiation or Chemotherapy Treatments: \_\_\_\_\_

#### Please fax Pathology, Radiology, Laboratory and Operative reports if not available 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: \_\_\_\_\_

Reports Needed:  Operative  Pathology  Radiology  Laboratory

Reviewing Provider's Signature: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Rev 02/19/09