LSU Health System
Interim LSU Hospital in New Orleans

Hepatitis C Clinic
Fax: 504.903.1605

Please indicate one of the following:
___LSU/Tulane Hepatitis C Clinics
___MCL Hepatitis C Clinic (Dr. Greene)

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:** ________________________________

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1° Contact Number: ______________________________ **2° Contact Number:** _________________________________
Email Address: ____

Please Note: this clinic is for the evaluation and treatment of 070.70 Hepatitis C antibody positive patients only.

The following must be available at the time of the appointment: Acute Hepatitis Panel, Hepatitis C genotype and viral load, AFP, ANA, CBC, CMP, HIV, TSH, and Ultrasound of the liver.

Clinical History Relevant to this Referral: ____
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____

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