

Patient Label/Stamp

Hypertensive Urgency 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, Please Complete the Following:

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

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

Mailing Address: _____

1* Contact Number: _____ 2* Contact Number: _____

Email Address: _____

Asymptomatic Hypertension (401.9):

401.9 Hypertension, asymptomatic, Stage 1: SBP 140-159, or DBP 90-99 (mm Hg)

401.9 Hypertension, asymptomatic, Stage 2: SBP >160, or DBP > 100 (mm Hg)

V68.1 Medication Prescription Refill Needed

Please indicate all that apply:

Abdominal Obesity: Waist circumference: >40 inches in Males; >35 inches in Females,

Abnormal Lipid Panel

History of CAD (MI, Unstable Angina, CAD procedure)

History of CAD Equivalent:

(Diabetes Mellitus, Symptomatic Carotid Artery Disease, Peripheral Vascular Disease, or Abdominal Aortic Aneurysm)

Medication Prescription Refill:

(needs referral to Primary Care/Medical Home, or will be out of medication before next available Primary Care appointment)

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. Location: _____

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

Rev 3/02/09