

ID--HOP Clinic

Fax: 504.903.6842



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:

424.90 Endocarditis

042 HIV/AIDS: symptomatic and/or being treated*

V08 HIV AB positive; asymptomatic and untreated*

*The following studies are not required but are recommended prior to scheduling an appointment and would be helpful if available for the first visit: CBC with Differential, Platelets, CD4 Cell Count, CMP, G-6-PD, Hepatitis B & C screen, HIV Viral Load, Lipid Profile, RPR, Total Testosterone level (males), Toxoplasmosis antibody, Uric Acid, Urinalysis, and Varicella antibody (females).

011-118 Tuberculosis and HIV/AIDS (without HIV/AIDS goes to Wetmore Clinic)

Hospital Discharge: ICD: _____ Diagnosis: _____

320-322 Meningitis

730 Osteomyelitis

091-097 Syphilis

682.9 Skin or soft tissue infections

Other: ICD: _____ Diagnosis: _____

Check here to Request Telephone Contact Regarding the Case you wish to Refer.

Contact Number: ____ - ____ - ____ - ____

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