LSU Health System
Interim LSU Hospital in New Orleans

Nephrology Clinic

Fax 504.903.2149

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:** ________________________________

Mailing address: ____

1˚ Contact Number: (__ __ __) __ __ __ -__ __ __ __ **2˚ Contact Number:** (__ __ __) __ __ __ -__ __ __ __

Email: ____

Indicate reason for referral (see workup below):

- ___585 CKD Stages 3,4,5 **(1, 2, 11)**
- ___753.1 Cystic Kidney Disease **(1, 11)**
- ___250.4 DM + Nephrotic Syndrome **(1, 2, 3, 11)**
- ___276.9 Fluid Electrolyte disorder **(1, 4, 11)**
- ___580.9 Glomerulonephritis **(1, 2, 11)**
- ___599.7 Hematuria (Urology Referral) **(1, 12)**
- ___572.4 Hepato-Renal Syndrome **(1, 13)**
- ___42 HIV with Proteinuria or elevated creatinine **(1,2, 11)**
- ___255.9 Hyperaldosteronism **(1, 4, 11)**
- ___403.9 Hypertension **(1, 11)**
- ___189 Kidney Mass **(1,2, 14)** (Referral from Urology Clinic)
- ___v42.0 Kidney Transplant Status **(1,2, 15)**
- ___203 Multiple Myeloma **(1, 6, 11)**
- ___592 Nephrolithiasis**(1, 4, 5, 11)**
- ___581.9 Nephrotic Syndrome **(1, 2, 7, 11)**
- ___277 Pheochromocytoma **(1, 8, 14)**
- ___v72.83 Pre-op Evaluation CKD **(1, 9, 16)**
- ___791 Proteinuria **(1, 2, 7, 11)**
- ___440.1 Renal Artery Stenosis **(1, 2, 11)**
- ___135 Sarcoidosis **(1, 2, 11)**
- ___710 SLE Nephritis **(1, 10, 11)**
- ___Other ICD _____ Diagnosis_______

(1) CBC, CMP, U/a, Urine Protein, Urine Creatinine
(2) Lipid Profile
(3) Hemoglobin A-1-c
(4) Urine Electrolytes and Osmolality
(5) Uric Acid
(6) UPEP and SPEP
(7) ANA, HBV, HCV, HIV, SPEP
(8) 24 Hour Urine for VMA and Metanephrines
(9) PT, INR
(10) ANA
(11) Renal Ultrasound
(12) Cystoscopy & Renal Ultrasound
(13) Abdominal and Renal Ultrasound
(14) CT Kidneys and Renal Ultrasound
(15) Transplant Ultrasound
(16) CXR and EKG (and ECHO with CHF)

Clinical History Relevant to this Referral: ____
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____

*****Please send copies of IMAGES and Reports of MRI/CT studies and copies of all test results not performed at MCLNO with the patient to the appointment.**

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 03/12/09