

Neurology 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 Complete the Following:

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

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

1° Contact Number: _____ 2° Contact Number: _____

Email Address: _____

Indicate Reason for Referral:

- | | | | |
|---------------------------------|--------------------------------------|---------------------------------|------------------------------|
| <input type="checkbox"/> 294.8 | Altered Mental Status
(Dementia) | <input type="checkbox"/> 340 | Multiple Sclerosis |
| <input type="checkbox"/> 781.3 | Ataxia | <input type="checkbox"/> 359.9 | Myopathy (muscle weakness) |
| <input type="checkbox"/> 351.0 | Bell's Palsy | <input type="checkbox"/> 355.9 | Neuropathy |
| <input type="checkbox"/> 432.9 | Cerebrovascular Disease or
Stroke | <input type="checkbox"/> 724.9 | Pain: Back (spine) |
| <input type="checkbox"/> 333.90 | Disorders of Movement | <input type="checkbox"/> 723.1 | Pain: Neck |
| <input type="checkbox"/> 780.4 | Dizziness | <input type="checkbox"/> 338.29 | Pain: Referred |
| <input type="checkbox"/> 784.0 | Facial pain | <input type="checkbox"/> 723.4 | Radiculopathy: Cervical |
| <input type="checkbox"/> 784.0 | Headache | <input type="checkbox"/> 724.2 | Radiculopathy: Lumbosacral |
| <input type="checkbox"/> 724.3 | Hydrocephalus: Congenital | <input type="checkbox"/> 393.4 | Restless Legs Syndrome |
| <input type="checkbox"/> 331.3 | Hydrocephalus: Communicating | <input type="checkbox"/> 345.10 | Seizure Disorder or Epilepsy |
| <input type="checkbox"/> 331.4 | Hydrocephalus: Obstructive | <input type="checkbox"/> 780.57 | Sleep Apnea |
| <input type="checkbox"/> 331.5 | Hydrocephalus: Normal
Pressure | <input type="checkbox"/> 724.00 | Spinal Stenosis |
| <input type="checkbox"/> 336.9 | Myelopathy | <input type="checkbox"/> 780.2 | Syncope (Non-Cardiac) |
| | | <input type="checkbox"/> 368.9 | Visual Disturbances |
| | | <input type="checkbox"/> Other: | |
| | | ICD 9: ___ | Diagnosis: _____ |

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