

Patient Label/Stamp

Neurosurgery 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:

- 191.9 Brain Tumor on MRI/CT: (NOT PREVIOUSLY DIAGNOSED OR TREATED)
- 191.9 Brain Tumor on MRI/CT: S/P TREATMENT with NEW NEUROLOGIC DEFICITS/SYMPTOMS
- 331.4 Hydrocephalus: MRI/CT Findings: obstructive hydrocephalus
- 331.4 Hydrocephalus with previous VP shunt placement
- 784.0 Headache: History of Trauma or change in post-concussive headache; associated symptoms/ findings with CT/MRI findings correlating with clinical scenario
- 345.10 Epilepsy: Failed Medical Management (*referral from Neurology or Epilepsy Center*)
- 724.9 Low back or 723.1 neck pain with Neurologic deficits (Weakness, numbness/loss of sensation, loss of bowel or bladder control)
- 724.9 Low back or 723.1 neck pain: CT/MRI findings with nerve root impingement or disc herniation correlating with clinical findings
- 350.1 Trigeminal Neuralgia: Failed medical management **REFER TO NEUROSURGERY WITH MRI OF BRAIN, FACE**
- 354.0 Carpal Tunnel Syndrome: failed medical management (*referral from PM&R or Neurology with documented abnormal EMG*)
- 781.0 Tremor: Failed medical management (*referral from Neurology or Movement Disorder Specialist*)
- Other ICD: _____ Diagnosis: _____

Clinical History Relevant to this Referral: _____

***Please send copies of IMAGES (NOT REPORTS) from MRI/CT studies for Neurosurgical review to facilitate appropriate triage and scheduling of patients.

____ Check here to request a phone call to discuss the case you wish to refer. Include the best contact number for the Neurosurgeon to call you to discuss the case if necessary: _____

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