

**Ob/Gyn Clinic**

**FAX: 504.903.8689 (LSU Patients)**

**FAX: 504.903.8682 (Tulane Patients)**

Patient Label/Stamp

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 Address: \_\_\_\_\_

**Please Indicate Reason for Referral:**

- |                                 |  |                                 |                          |
|---------------------------------|--|---------------------------------|--------------------------|
| <input type="checkbox"/> V72.31 | Annual exam, routine                             | <input type="checkbox"/> 626.2  | Menorrhagia/anemia       |
| <input type="checkbox"/> 795.0  | Abnormal pap/HPV (include HPV testing if ASCUS*) | <input type="checkbox"/> 653.7  | MFM ultrasound           |
| <input type="checkbox"/> 637    | Abortion, incomplete                             | <input type="checkbox"/> 620.2  | Ovarian Cyst             |
| <input type="checkbox"/> 632.0  | Abortion, missed                                 | <input type="checkbox"/> 789.3  | Pelvic mass              |
| <input type="checkbox"/> 626.0  | Amenorrhea                                       | <input type="checkbox"/> 625.9  | Pelvic Pain              |
| <input type="checkbox"/> 627.1  | Postmenopausal Bleeding                          | <input type="checkbox"/> V22.1  | Pregnancy Care           |
| <input type="checkbox"/> 633    | Ectopic Pregnancy                                | <input type="checkbox"/> V23.9  | Pregnancy High Risk      |
| <input type="checkbox"/> 628.9  | Fertility Issues                                 | <input type="checkbox"/> 618.81 | Prolapse                 |
| <input type="checkbox"/> 218    | Fibroids, uterine                                | <input type="checkbox"/> V65.45 | STD management           |
| <input type="checkbox"/> 788.3  | Incontinence                                     | <input type="checkbox"/> 616.10 | Vaginal discharge        |
| <input type="checkbox"/> 183.8  | Malignancy, suspected (ovary, uterus, cervix)    | <input type="checkbox"/> 623.8  | Vaginal or vulvar lesion |
|                                 |  | <input type="checkbox"/> Other  | ICD: _____               |
|                                 |  |                                 | Diagnosis: _____         |

(\*ASCUS= Atypical Squamous Cells of uncertain Significance)

**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: \_\_\_\_\_