

Oral Maxillo-Facial Surgery Clinic

Fax: 504.903.3479

Referral from: BMC EKL LJC LAK
 LIH UMC WOM Other: _____

Patient Label/Stamp

Attending Provider: _____ ID Number: _____

If Patient Label/Stamp is Not Available Please Complete the Following:

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

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

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

Email Address: _____

1. Indicate Priority: urgent routine

2. Select Reason for Referral:

- 149.8 Oral / Head and Neck pathology
- 744.9 Facial Deformity- congenital/developmental
- 959.09 Facial Deformity- post-traumatic (i.e. post traumatic nasal deformity)
- 959.09 Trauma -Face and Mandible (acute)
- 682.0 Facial Infection
- 528.9 Odontogenic infection
- 738.1 Cosmetic surgery
- 738.10 Facial Reconstruction

3. Please indicate patient's functional health status:

- P1: **Normal healthy patient** (heart, lungs, liver, kidneys, and CNS are within normal limits)
- P2: **Mild systemic disease** (able to walk up one flight of stairs or walk two level city blocks but must rest at the completion of the task because of distress—chest pain, undue fatigue, or shortness of breath)
- P3: **Severe systemic disease** (able to walk up a flight of stairs or walk two level city blocks but must stop [at least once] *before reaching their goal* because of distress)
- P4: **Severe systemic disease that is a constant threat to life** (unable either to walk up a flight of stairs or walk two level city blocks)

Clinical History Relevant to this Referral: _____

Indicate co-morbid conditions for this patient:

- Anticoagulation Therapy Bisphosphonate Therapy Cancer
- Cardiac Disease Lung Disease Morbid Obesity
- Recent (< 6 months) MI or CVA Sickle Cell Disease Uncontrolled Diabetes
- Other: _____

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: _____

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