

Ophthalmology Clinic

Fax: 504.903.1605

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: _____

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

Email Address: _____

Please Indicate Reason for Referral:

- | | | | |
|---------------------------------|-------------------------|---------------------------------|--|
| <input type="checkbox"/> 042 | AIDS | <input type="checkbox"/> 368.15 | Diplopia |
| <input type="checkbox"/> 362.34 | Amaurosis Fugax | <input type="checkbox"/> 216.1 | Eyelid: skin lesion |
| <input type="checkbox"/> 351.0 | Bell's palsy | <input type="checkbox"/> 365.11 | Gaucoma, Chronic |
| <input type="checkbox"/> 368.8 | Blurred vision | <input type="checkbox"/> 365.20 | Glaucoma, Primary angle |
| <input type="checkbox"/> 366.16 | Cataract | <input type="checkbox"/> 401.9 | Hypertension |
| <input type="checkbox"/> 372.30 | Conjunctivitis | <input type="checkbox"/> 362.11 | Hypertensive retinopathy |
| <input type="checkbox"/> 918.1 | Corneal Abrasion | <input type="checkbox"/> 364.41 | Hyphema |
| <input type="checkbox"/> 930.0 | Corneal Foreign body | <input type="checkbox"/> 379.91 | Pain in eye |
| <input type="checkbox"/> 372.72 | Conjunctival hemorrhage | <input type="checkbox"/> 078.5 | Retinitis, CMV (+363.13) |
| <input type="checkbox"/> 921.3 | Contusion, Eyeball | <input type="checkbox"/> 378.54 | Sixth nerve palsy |
| <input type="checkbox"/> 362.03 | Diabetic retinopathy | <input type="checkbox"/> 368.14 | Visual Disturbance (Metamorphopsia) |

Other ICD: _____ Diagnosis: _____

Clinical History Relevant to this Referral: _____

Indicate co-morbid conditions for this patient:

- | | | |
|--|---|--|
| <input type="checkbox"/> Anticoagulation Therapy | <input type="checkbox"/> Bisphosphonate Therapy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Morbid Obesity |
| <input type="checkbox"/> Recent (< 6 months) MI or CVA | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Uncontrolled Diabetes |
| <input type="checkbox"/> 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: _____

Rev 02/19/09