LSU Health System
Interim LSU Hospital in New Orleans

Ophthalmology Mobile Unit

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: ________________________________

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1˚ Contact Number: _________________________ **2˚ Contact Number:** ____________________________

Email Address: ____

Please Indicate Reason for Referral

___368.80 Refraction for glasses/blurred vision

___250 Diabetes

___365.11 Glaucoma

___366.16 Cataracts

___401.1 Hypertension

___Other ICD: ______ Diagnosis: ____

Clinical History Relevant to this Referral: ____

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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: __________________

OFFICE USE ONLY: Appointment Date: _____/______/_____ Time: __:__ am/pm.

If not scheduled, Indicate Reason & Recommendation: ____

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Reviewing Provider's Signature: ____________________________________ ID Number: _______________

Contact Number: __ __ __-__ __ __-__ __ __ __

Rev 02/19/09