

Physiatry Clinic (Physical Medicine & Rehabilitation)

Patient Label

Fax 504.903.1605

From: BMC EKL LJC LAK ILH UMC WOM Other: _____

Attending Provider: _____ **ID Number:** _____

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

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

Mailing Address: _____

1° Contact Number: (____) _____ - _____ 2° Contact Number: (____) _____ - _____

Indicate Reason for Referral:

Acute Musculoskeletal Pain:

- 847.9 Back Pain
- 727.3 Bursitis
- 719.9 Joint Pain
- 729.5 Limb Pain
- 729.1 Myofascial Pain
- 723.1 Neck Pain
- 726.90 Tendonitis

Peripheral Neuropathies:

- 250.6 Diabetic Neuropathy
- 357.9 Polyneuropathy
- 355.9 Mononeuritis
- 354.5 Mononeuritis Multiplex

Suspected Neuropathic Conditions:

- 729.5 Pain in Limb
- 729.2 Radiculopathy

Rehabilitation For:

- V57.8 Amputation
- V53.7 Bracing Evaluation
- 854 Head Injury
- 729.2 Nerve Injury
- 728.87 Neurologic Weakness
- 344.1 Paraplegia
- 344.00 Quadriplegia
- 728.85 Spasticity Problem
- 431 Stroke

Entrapment Neuropathies:

- 354.0 Carpal Tunnel Syndrome
- 354.2 Ulnar Nerve Entrapment
- 355.5 Tarsal Tunnel Syndrome

Other: ICD: _____ DX: _____

Is this patient on Narcotics? Yes No

Have the patient bring copies of lab work, studies, and medical records not available at ILH.

Clinical History Relevant to this Referral: _____

Referring Provider's Signature: _____ **ID Number:** _____

Contact No.: (____) _____ - _____ **Referring Service/Clinic:** _____

Fax No.: (____) _____ - _____ **Email:** _____

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

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: (____) _____ - _____ Rev 07/26/09