

Plastic Surgery Clinic

Fax 504.903.1605

Patient Label

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

Attending Provider: _____ ID Number: _____

If Patient label is Not Available Complete the Following:

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

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

Primary Contact Number: _____ Secondary Contact Number: _____

Email: _____

Please Indicate Reason for Referral:

- 611.8 Breast Asymmetry/ Deformity
- 611.9 Breast Reconstruction s/p mastectomy
- 611.9 Breast Implant Complication
- 749.00 Cleft Lip/Palate
- 707.00 Decubitus ulcer (Please order appropriate x-rays, CMP, ESR and CRP)
- 744.3 Ear deformity
- 374.89 Eyelid deformity or ptosis
- 738.19 Facial deformity or scarring
- 729.6 Foreign Body (residual), Soft Tissue
- 228 Hemangioma or Vascular Malformation
- 701.4 Keloid Scar (Please try steroid injections prior, Dermatology for smaller lesions)
- 906.9 Late Effect of Burn: Face, Head, Neck, Trunk, Lower extremity
- 272.6 Lipodystrophy
- 611.1 Male Gynecomastia
- 216.9 Mole (Nevus) (Location _____)
- 478.19 Nasal Airway Obstruction
- 738.0 Nasal Deformity, acquired (congenital = 748.1)
- 879.8 Open Wound (Location _____)
- 709.2 Scar contraction evaluation for release procedure
- 239.2 Skin Cancer (Location _____)
- Other ICD: _____ Diagnosis: _____

****Please page the Plastic Surgery Resident on call for acute Facial Trauma referrals (504-903-3000)****

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.

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

Rev 02/19/09