

**Podiatry Clinic**

Fax: 504.903.1605

Referral from:  BMC  EKL  LJC  LAK  
 LIH  UMC  WOM  Other: \_\_\_\_\_

Patient Label/Stamp

Attending Provider: \_\_\_\_\_ ID Number: \_\_\_\_\_

*If Patient Label 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  ASAP  Next Available

2. Is this Patient Diabetic:  yes  no

3. Select Reason for Referral:

- |  |  |
|--|--|
| <input type="checkbox"/> 781.2 Abnormal Gait                   | <input type="checkbox"/> 274.9 Gout  |
| <input type="checkbox"/> V49.0 Amputation                      | <input type="checkbox"/> 735.4 Hammer Toes                                     |
| <input type="checkbox"/> 682.7 Abscess, foot or ankle          | <input type="checkbox"/> 726.71 Heel Cord Tightness                            |
| <input type="checkbox"/> 845.00 Ankle Sprain                   | <input type="checkbox"/> 703.0 Ingrown Toenail                                 |
| <input type="checkbox"/> 715.90 Arthritis                      | <input type="checkbox"/> 355.6 Neuroma   |
| <input type="checkbox"/> 727.1 Bunion                          | <input type="checkbox"/> 730.20 Osteomyelitis                                  |
| <input type="checkbox"/> 682.9 Cellulitis: foot, ankle, or toe | <input type="checkbox"/> 735.8 Overlapping Toes                                |
| <input type="checkbox"/> 713.5 Charcot Joint                   | <input type="checkbox"/> 729.5 Pain: Ankle or Foot                             |
| <input type="checkbox"/> 718.47 Contracture: Ankle or Foot     | <input type="checkbox"/> 440.20 Peripheral Vascular Disease                    |
| <input type="checkbox"/> 924.3 Contusion: Toenail or Toe       | <input type="checkbox"/> 728.71 Plantar Fasciitis                              |
| <input type="checkbox"/> 700 Corns, Callosities                | <input type="checkbox"/> 355.5 Tarsal Tunnel Syndrome                          |
| <input type="checkbox"/> 736.70 Deformity of Foot              | <input type="checkbox"/> 735.9 Toe Deformities                                 |
| <input type="checkbox"/> 250.0 Diabetic Foot Care(+357.2)      | <input type="checkbox"/> 110.1 Toenail: Dystrophy, Onycholysis,<br>Hypertrophy |
| <input type="checkbox"/> 250.60 Diabetic Neuropathy            | <input type="checkbox"/> 707.9 Ulcer   |
| <input type="checkbox"/> 729.6 Foreign Body                    | <input type="checkbox"/> 459.81 Venous Insufficiency                           |
| <input type="checkbox"/> 829.0 Fracture Closed                 | <input type="checkbox"/> 707.10 Venous Stasis Ulcer                            |
| <input type="checkbox"/> 727.43 Ganglion Cyst                  | <input type="checkbox"/> Other ICD: _____ Diagnosis: _____                     |
| <input type="checkbox"/> 785.4 Gangrene                        |  |

Clinical History Relevant to this Referral: \_\_\_\_\_

\*\*\*Please indicate co-morbid conditions for this patient: \_\_\_\_\_  
 Cardiac Disease  Diabetes Mellitus  Anticoagulation Therapy  
 Lung Disease/Morbid Obesity

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