

Patient Label/Stamp

Primary Care Referral

Fax: 504. 903.1605

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

Attending Provider: _____ ID Number: _____

Indicate All Clinics Where Patient has previously been treated:

- Community Health: Jefferson Parish Community Health: St Charles Parish
- Daughters of Charity Douglass Excelth, Inc.
- Health Dept: CITY Health Dept: STATE LIH Medicine: LSU
- LIH Medicine: Tulane Jackson Barracks Martin Behrman
- Murray-Henderson New Orleans East St Thomas Clinic

Requested Followup: < 1 week 1-2 weeks 4 weeks 3 mo. 6 mo.

If Patient Label/Stamp is Not Available Complete the Following:

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

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

Mailing Address: _____

1* Contact Number: _____ 2* Contact Number: _____

Email Address: _____

- Indicate Reason for Referral:
- V70.0 Health Checkup 787.1 Heartburn/GERD
 - 716.5 Arthritis/Gout 428.0 Heart Failure
 - 519.9 Asthma/COPD/Lung Disease 414.0 History: CAD (MI, Unstable Angina, CABG, Stent)
 - 285.9 Anemia 272.4 Hyperlipidemia
 - 794.8 Abnormal Liver Function Tests 401.1 Hypertension
 - 250.00 Diabetes Mellitus Type I 278.00 Obesity
 - 250.00 Diabetes Mellitus Type II 780.50 Sleep Apnea
 - 300.4 Depression/Anxiety Other: ICD: _____
 - 784.0 Headache DX: _____

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. Location: _____

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

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