

## Rheumatology & Immunology 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/Stamp is Not Available Complete the Following:*

Patient's Name: \_\_\_\_\_ Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical Record Number: \_\_\_\_\_

1° Contact Number: \_\_\_\_\_ 2° Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Indicate reason or referral (see workup below):**

- |  |   |
|--|---|
| <input type="checkbox"/> 720.0 Ankylosing Spondylitis (1,2)                | <input type="checkbox"/> 446.0 Microscopic Polyarteritis (1, 9)         |
| <input type="checkbox"/> 716.9 Arthritis, Enteropathic (1, 2)              | <input type="checkbox"/> 710.9 Mixed Connective Tissue Disorder (1, 12) |
| <input type="checkbox"/> 136.1 Behcet's Syndrome (1)                       | <input type="checkbox"/> 715.90 Osteoarthritis/DJD (1)                  |
| <input type="checkbox"/> 446.4 Churg-Strauss Arteritis (1, 3)              | <input type="checkbox"/> 446.0 Polyarteritis Nodosa (1,9)               |
| <input type="checkbox"/> 710.1 CREST-Scleroderma (1, 4)                    | <input type="checkbox"/> 710.4 Polymyositis (1, 5)                      |
| <input type="checkbox"/> 710.3 Dermatomyositis (1, 5)                      | <input type="checkbox"/> 712.0 Pseudogout (Chondrocalcinosis) (1)       |
| <input type="checkbox"/> 728.89 Eosinophilic Fasciitis (1)                 | <input type="checkbox"/> 696.0 Psoriatic Arthritis (1, 2)               |
| <input type="checkbox"/> 273.2 Ess. Cryoglobulinemic Vasculitis (1,7,8)    | <input type="checkbox"/> 443.0 Raynaud's Phenomenon (1, 13)             |
| <input type="checkbox"/> 729.1 Fibromyalgia (1, 6)                         | <input type="checkbox"/> 711.10 Reiter's Syndrome (1, 2)                |
| <input type="checkbox"/> 446.5 Giant Cell (Temporal) Arteritis (1, 9)      | <input type="checkbox"/> 733.99 Relapsing Polychondritis (1)            |
| <input type="checkbox"/> 274.0 Gout (1, 14)                                | <input type="checkbox"/> 714.0 Rheumatoid Arthritis (1, 10)             |
| <input type="checkbox"/> 287.0 Henoch-Schonlein Purpura (1, 9)             | <input type="checkbox"/> 710.2 Sjogren 's syndrome (1,12)               |
| <input type="checkbox"/> 287.0 Hypersensitivity(allergic)Vasculitis (1, 9) | <input type="checkbox"/> 446.7 Takayasu Arteritis (1, 9)                |
| <input type="checkbox"/> 714.9 Joint Pain, inflammatory (1, 10)            | <input type="checkbox"/> 447.6 Vasculitis (1, 9)                        |
| <input type="checkbox"/> 710.0 Lupus (SLE) (1, 11)                         | <input type="checkbox"/> 446.4 Wegener's Granulomatosis (1, 3)          |
|  | <input type="checkbox"/> Other ICD _____ Diagnosis _____                |

(1) CBC, CMP, ESR, CRP, UA

(2) HLA-B27

(3) ANCA, C-ANCA, P-ANCA

(4) ANA, Scl-70, Anti-Centromere, Antibodies

(5) ANA, Jo-1

(6) TSH, Free T4

(7) Cryocrit, SPEP, UPEP

(8) HBV, HCV

(9) ANCA

(10) ANA, RF, Anti-CCP Antibodies

(11) ANA, C3, C4, U/A

(12) ANA, ENA Panel

(13) ANA

(14) Uric Acid

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