

SHAP-DM Clinic

Fax 504.903.1605

Patient Label/Stamp

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

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: _____

Please indicate all that apply:

401.9 Hypertension:

HPTN, Stage 1 SBP 140-159 or DBP 90-99 with Diabetes Mellitus

HPTN, Stage 2 SBP >160 or DBP > 100 with Diabetes Mellitus

250.00 Diabetes Classification:

HgbA1c > 10

272.4 Hyperlipidemia:

TGL greater than 400

LDL greater than 190

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