LSU Health
Healthcare Network

REFERRAL REQUEST

Today's Date: ____________________

Specialty Requested: (Check all that apply)

□ Allergy/Immunology □ Behavioral Health □ Cardiology/Electrophysiology □ Endocrinology

□ GI □ Geriatrics □ Hem/Onc □ Nephrology □ Neurology □Neurosurgery □ OB/GYN □ MFM

□ Urogynecology □ OMFS □ Ophthalmology □ Orthopedics □ Podiatry □ Pediatrics

□ Plastic Surgery □ Primary Care □ Pulmonary □ Rheumatology □ ColoRectal Surgery

□ General Surgery □ Hand Surgery □ Vascular Surgery □ Surgical Oncology □ Urology □ Vein Care

Provider Preference: ___________________________ *OR* **First Available Appointment**

Indication: ____

Referring Provider: ____

Patient Name (Last, First): ___________________________________ DOB: ___________________

Preferred Phone #: ________________________ Insurance Plan: __________________________

Special Instructions:

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Office contact: ________________________

Phone #: _____________________________ Fax #: ________________________________

Please fax this form with patient face sheet and all necessary medical records to: Referral Specialist at ***1.866.338.8422.***

Thank you for your referral to LSUHN. We are honored to care for your valued patient.

For Internal LSUHN use only:

Date of Patient Contact: ____________________________ Referral Specialist: _______________________________

Appointment Date: ___________________ Provider: ______________________ Location: _____________________

Date Referring Provider/Office Notified: _________________________

Comments: ____

06.09.2016 AG