Comprehensive Pulmonary Hypertension Center

Referral request

University Medical Center New Orleans
LCMC Health

Thank you for choosing University Medical Center New Orleans. We look forward to partnering with you in your patient's care. Please complete and submit or fax form.

Date of request:__________ Routine Urgent

pages:__________

Referring provider information

Referred by (MD):__________

Name of medical group:__________

Office phone (include area code):__________ Office fax:__________

Primary care physician:__________ Phone: __________

Address:__________

City:__________ State:__________ Zip: __________

This form completed by:__________ Phone: __________

Patient information (Please provide copy of patient demographics/face sheet)

Last name:__________ First name:__________ MI:__________

Date of birth:__________ Gender: Male Female

Primary phone:__________ Alternate phone: __________

Patient's address:__________

City:__________ State:__________ Zip: __________

Primary language:__________

Reason for referral

Diagnosis/ICD:__________

Service/Specialty requested:__________

Physician being requested:__________

Type of service requested: Consultation 2nd opinion Other (please specify):__________

Reason for referral:__________

Documentation required (Please fax with this form)

- Copy of insurance card (both sides)
- Recent clinic note, history, and physical
- Demographics and referral order
- Authorization information (if required)
- List of current medications
- All lab work
- PFT's and 6 Minute Walk
- Chest X-rays and/or CT scans
- Echocardiogram
- Cardiac catheterization
- V/Q Scan
- Sleep study (if already done)

Submit or Print

To email To fax

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umcno.org/CPHC

23-25669-0602