

# TELEMEDICINE REFERRAL

Please legibly complete this entire form for LHCC patients being referred to LSU HealthCare Network telemedicine services.

REFERRING FACILITY INFORMATION – <b>REQUIRED</b>			
Referring Provider Name (as it appears on medical license):		Referring Facility Name:	
Street Address:		Medical License #:	NPI #:
City:	State and Zip Code:	E-mail Address:	
Referring Provider Phone #: ( )		Referring Provider FAX #: ( )	
Referring Provider Signature:			Date:

TELEMEDICINE SERVICE REQUESTED			
<input type="checkbox"/> Adult (>18 years old)	<input type="checkbox"/> Otolaryngology (ENT)	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Psychiatry for: <input type="radio"/> Treatment <input type="radio"/> Medication Management
<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Pulmonary		<input type="radio"/> Therapy <input type="radio"/> Psychological Evaluation/Testing
Reason for Consultation: <i>Attach current related medical information (labs, reports, notes, etc.)</i>			
Diagnosis Code(s): _____			

PATIENT INFORMATION			
Name (Last, First, Middle Name):		Salutation: <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Social Security #:	Preferred Language:	Race: <input type="checkbox"/> Caucasian or White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Unknown/Declined
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	Religion: <input type="checkbox"/> Baptist <input type="checkbox"/> Catholic <input type="checkbox"/> Jehovah's Witness <input type="checkbox"/> Muslim <input type="checkbox"/> Pentecostal <input type="checkbox"/> Non-Denominational <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____
Street Address:		E-mail Address:	
City:	State and Zip Code:	Home Phone #: ( )	
Work Phone #: ( )	Cell Phone #: ( )	Preferred Contact #:	
Occupation:		Employer:	

EMERGENCY CONTACT INFORMATION			
Name of local friend or relative (not living at the same address):		Relationship to Patient:	
City:	State:	Home Phone #: ( )	Mobile Phone #: ( )
Next of Kin Name:		Phone:	Relationship:
Guardian Name:		Phone:	Relationship:

INSURANCE INFORMATION (Attach a copy of the insurance card & photo ID)			
Primary Insurance Carrier:		Primary Policy Holder's Name:	Patient Relationship to Policy Holder:
Member ID/Policy #:	Group #:	Policy Holder's Social Security #:	Policy Holder's Date of Birth:
Name of Secondary Insurance (if applicable):	Secondary Policy Holder's Name:	Secondary Policy #:	Secondary Group #:

PHARMACY INFORMATION		
Preferred Pharmacy:	Pharmacy Address:	Pharmacy Phone #: ( )

FAX Completed Form to (504) 568-3362  
Include Copy Insurance Card & Photo ID (front & back)