louisiana healthcare connections

TELEMEDICINE REFERRAL

LSUHealth Healthcare Network

LSUHealth LALLIE KEMP REGIONAL MEDICAL CENTER

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

REFERRING FACILITY INFORMATION – *REQUIRED*

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

☐ **Adult** *(>18 years old)*

☐ **Otolaryngology (ENT)** ☐ **Orthopedics** ☐ **Psychiatry** *for:* ○ *Treatment* ○ *Medication Management*

☐ **Ophthalmology** ☐ **Pulmonary** ○ *Therapy* ○ *Psychological Evaluation/Testing*

Reason for Consultation: ***Attach current related medical information (labs, reports, notes, etc.)***

*Diagnosis Code(s):*_______________

PATIENT INFORMATION

Name (Last, First, Middle Name):		Salutation: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Social Security #:	Preferred Language:	Race: ☐ Caucasian or White ☐ Black ☐ Asian ☐ Other:__________________ ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown/Declined	
Date of Birth:	Gender: ☐ Male ☐ Female	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	
Street Address:		Religion: ☐ Baptist ☐ Catholic ☐ Jehovah's Witness ☐ Muslim ☐ Pentecostal ☐ Non-Denominational ☐ Unknown ☐ Other:____________________________	
City:	State and Zip Code:	E-mail Address:	
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 #: ( )

LSUHealth HEALTH CARE SERVICES DIVISION

FAX Completed Form to (504) 568-3362

Include Copy Insurance Card & Photo ID *(front & back)*