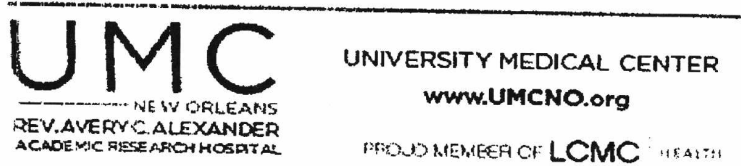


**Transmission Report**

Date/Time 08-21-2019 03:42:46 p.m. Transmit Header Text  
Local ID 1 5047023190 Local Name 1 UMC AC3 CLN2 FAX

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Phone Number: (504) 702-3440

Fax Number: (504) 702-5738

**Fax Transmittal Sheet**

To: Dr. Kevin McLaughlin From: UMC HEAD and NECK CT

Fax: 985-867-5498 Pages: 14

Phone: \_\_\_\_\_ Date: 8/21/2019

RE: Jeffrey Bodin CC: \_\_\_\_\_

Comments: Referral

Total Pages Scanned : 14

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001	090	9858675498	03:38:23 p.m. 08-21-2019	00:03:00	14/14	1	EC	HS	CP21600

Abbreviations:

HS: Host send      PL: Polled local      MP: Mailbox print      CP: Completed      TS: Terminated by system  
HR: Host receive      PR: Polled remote      RP: Report      FA: Fail      G3: Group 3  
WS: Waiting send      MS: Mailbox save      FF: Fax Forward      TU: Terminated by user      EC: Error Correct

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**UMC**

NEW ORLEANS  
REV. AVERY C. ALEXANDER  
ACADEMIC RESEARCH HOSPITAL

UNIVERSITY MEDICAL CENTER

www.UMCNO.org

PROUD MEMBER OF LCMC HEALTH

Phone Number: (504) 702-3440

Fax Number: (504) 702-5738

## Fax Transmittal Sheet

To: Dr. Kevin McLaughlin From: UMC HEAD and NECK CT

Fax: 985-867-5498 Pages: 14

Phone: \_\_\_\_\_ Date: 8/21/2019

RE: Jeffery Bodin CC: \_\_\_\_\_

Comments: Referral

**SPECIALTY CLINIC REFERRAL FORM**

Date: 8/21/2019

Clinic Referral to:  MCLNO: Adult Medicine  MCLNO: Neurology  
 MCLNO: HOP/Infectious Disease  MCLNO: Dermatology  
 MCLNO: Hepatitis C  Other Clinic Dr. Kevin McLaughlin  
 \_\_\_\_\_ Clinic at \_\_\_\_\_ Hospital

Referral from:  MCL ESU  Primary Care Clinic  
 Other MCL Facilities: UMC NO ENT Clinic

**For Chabert Ortho Clinic Only**  
 Urgent  Routine  
 Chronic Spine Pain  
 Male  Female

Patient's Name: Jeffery Bodin

Date of Birth: 5/22/1997 Age: 22 SSN: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Alternate Contact #: \_\_\_\_\_

Address: \_\_\_\_\_

Reason for Referral: Patient seeking Sleep Medicine trained person to help with his narcolepsy.

Diagnosis for Referral: Narcolepsy ICD-10 Code: G47.419

Onset of Illness: \_\_\_\_\_

Treatment Given: \_\_\_\_\_

Specialist Notified?  Yes  No Name: \_\_\_\_\_ Date: \_\_\_\_\_

Desired appointment interval:

Within two weeks  Within one month  Next available (within two months)

Other \_\_\_\_\_ (i.e. specific month, day of week, time, etc.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Referring Physician Signature / Stamp

Stephan Warr  
 Attending Physician

8/21/2019  
 Date

Printed name of approving physician

Date of Approval

For Appointment Office Use

Approved  Denied  Referred to primary care clinic or provider \_\_\_\_\_

- |  |  |
|--|--|
| _____ Incomplete request                       | _____ Appropriate diagnostic studies not ordered prior to referral             |
| _____ Lack of attending approval               | _____ Appropriate diagnostic studies not completed prior to referral           |
| _____ Inappropriate referral                   | _____ Chronic problem, patient previously discharged from clinic               |
| _____ Clinic not available from referring area | _____ Patient has Tulane hospital number, LSU clinic referral                  |
| _____ Service requested on wrong form          | _____ Patient has LSU hospital number, Tulane clinic referral                  |
| _____ Community Care Referral needed           | _____ Service not available at MCLNO, referred to primary care clinic/provider |
| _____ Other _____                              |  |