

Transmission Report

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Date/Time
Local ID 1

08-21-2019
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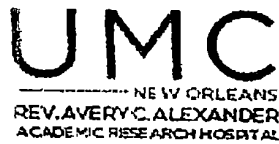
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Transmit Header Text
Local Name 1

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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: Jeffrey Bodin CC: _____

Comments: Referral

Total Pages Scanned : 14

Total Pages Confirmed : 14

No.	Job	Remote Station	Start Time	Duration	Pages	Line	Mode	Job Type	Results
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Abbreviations:

HS: Host send
HR: Host receive
WS: Waiting send

PL: Polled local
PR: Polled remote
MS: Mailbox save

MP: Mailbox print
RP: Report
FF: Fax Forward

CP: Completed
FA: Fail
TU: Terminated by user

TS: Terminated by system
G3: Group 3
EC: Error Correct

SPECIALTY CLINIC REFERRAL FORM

Date: 8/21/2019

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

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

Stephanie 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

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