Transmission Report

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SCANNED

Date/Time	08-21-2019	03:42:46 p.m.	Transmit Header Text	
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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. Kevien McLaughlin **From:** UMC HEAD and NECK CT

Fax: 985-867-5498 **Pages:** 14

Phone: **Date:** 8/21/2019

RE: Jeffery 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
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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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: UMCNO ENT Clinic

For Chabert Ortho Clinic Only
☐ Urgent ☐ Routine
☐ Chronic Spine Pain

Patient's Name: Jeffery Bodin ☑ Male ☐ Female

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 Wargo
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