University Medical Center New Orleans
Comprehensive Pulmonary Hypertension Center
2000 Canal Street New Orleans, LA 70112
Office 504.702-5057 | Fax 504.702-5728
www.umcno.org/CPHC

REFERRAL REQUEST

Thank you for choosing UMC New Orleans. We look forward to partnering with you in your patient's care. Please complete and fax this form to 504.702-5728.

Date of Request: _____ ☐ Routine ☐ Urgent
Pages: _____

REFERRING PROVIDER INFORMATION:

Referred by (MD): _____
Name of Medical Group: _____
Office Phone (include area code): _____ Office Fax: _____
Primary Care Physician: _____ Phone: _____
Address: _____ City: _____ ZIP: _____
This form completed by: _____ Phone: _____

PATIENT INFORMATION (*Please provide copy of patient demographics/face sheet*):

Last Name: _____ First Name: _____ MI: _____
DOB: _____ Gender: ☐ Male ☐ Female
Primary Phone: _____ Alternate Phone: _____
Patient's Address: _____
City/State/Zip: _____
Primary Language: _____

REASON FOR REFERRAL:

Diagnosis/ICD: _____
Service/Specialty Requested: _____
Physician Being Requested: _____
Type of Service Requested: ☐ Consultation ☐ 2nd Opinion ☐ other (please specify): _____
Reason for Referral: _____

DOCUMENTATION REQUIRED *(Please fax with this form)*:

☐ Copy of insurance card (*both sides*)	☐ PFT's and 6 Minute Walk
☐ Recent clinic note + History & Physical	☐ Chest X-rays &/or CT Scans
☐ Demographics and referral order	☐ Echocardiogram
☐ Authorization information (*if required*)	☐ Cardiac catheterization
☐ List of current medications	☐ V/Q Scan
☐ All Lab work	☐ Sleep Study (if already done)

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