

NAME OF ORGANIZATION  
ADDRESS, PHONE

**REFERRAL TO:**

- Tulane Covenant House Clinic – 611 N. Rampart St. 504.584.1167
- St. Anna’s H.A.R.P. – 1313 Esplanade Ave. 504.232.4403
- St. Thomas Clinic - 1020 Saint Andrew Street 504.529.5558
- Trinity Counseling and Training Center – 2108 Coliseum 504.522.7557
- Daughters of Charity Clinic – St. Cecelia - 4201 N.Rampart St. 504.945.1531
- Daughters of Charity Clinic – Uptown - 2820 Napoleon Ave., Suite 810 504.207.3060
- Daughters of Charity Clinic – Metairie - 111 N. Causeway Blvd. 504.482.0084
- New Orleans Musician’s Clinic - 2820 Napoleon Ave., Suite 890 504.412.1366
- Lower 9<sup>th</sup> Ward Clinic - 5228 St. Claude Ave. 504.309.0918
- University Hospital ER - 2021 Perdido St 504.903.3000
- Other (please identify) \_\_\_\_\_

**PATIENT INFO:** Name: \_\_\_\_\_ DOB \_\_\_\_\_ Gender:  F  M

Address \_\_\_\_\_ Phone \_\_\_\_\_

Guardian/advocate/responsible party \_\_\_\_\_ Phone \_\_\_\_\_

*Reason for referral:* \_\_\_\_\_

*Please check all that apply:*

- Continuity Care** - Please assume care of patient for this / all problem(s)
- Follow-up** - Please evaluate and treat for this problem
- Appointment Scheduling** - Please contact the patient to schedule appointment

**NAME/TITLE OF PERSON MAKING REFERRAL:** (print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Patient's pertinent medical record is attached for purpose of continuity of care. # of pages: 1 2 3 \_\_\_\_

**CONSENT TO FOLLOW-UP WITH RECEIVING AGENCY**

My signature below indicates that I have given permission for a referral to be made and pertinent medical records to be shared with the agency indicated above under “Referral To”. I hereby consent to the release of appointment dates, attendance at appointments and periodic updates of my overall treatment from this referral to [NAME OF ORGANIZATION] by this same agency. This information is confidential and is only to be used to improve and coordinate services. I understand that I can revoke this consent at any time.

Client/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Receiving Agency:** To assist in confirming successful referral, please complete & fax this form back to [NAME OF ORGANIZATION], [PHONE] when patient is seen. Thank you.

**Date Seen:** \_\_\_\_\_ **Name of Clinic/MD:** \_\_\_\_\_

**Office Staff Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_