LSU Health System – Evidence Based Offender Consult Form -- For Initial (or NEW) requests

ENT: Airway, Throat, Voice, Neck

Circle one: ROUTINE URGENT

Fax to 504.568.3360 (along with supporting documentation) **Date of Request: ___ /____ / _____**

Gender (circle one) M F

Offender Name (Last, First): _____ Date Of Birth: ___ /____ / _____

Correctional Facility: _____Offender ID Number: _____

LSU LSU MRN: _____@ (Circle One) BMC, EKL, LAK, LJC, MCL, UMC, WOM

Indicate Reason for Referral:

___519.8 Airway Obstruction or Stridor

___786.2 Chronic Cough

___787.2 Dysphagia

___528.3 Fistula

___784.49 Hoarseness

___785.6 Lymphadenopathy (including Chronic Adenoid Hypertrophy):
Obtain CBC, HIV Test, Monospot, EBV titers, CXR, Fine Needle Aspiration of Lymph Node if available. Consider empiric course of antibiotic therapy.

___780.57 Obstructive Sleep Apnea or Snoring

___527.2 Salivary Disorders: Inflammation and/or Stones
Treat before referral with antistaphylococcal antibiotics, sialagogues (lemon drops, sour candy, etc.), NSAIDS, and warm compresses to inflamed gland.

___474.00 Tonsillitis
Indications for ENT referral: more than 6 episodes in one year, 5 or more episodes yearly for 2 or more years, or 4 or more episodes yearly for 3 or more years, or 2 or more cases of peritonsillar abscess. Treat acute tonsillitis empirically with pen VK, amoxicillin, or clindamycin.

___478.30 Vocal Cord Paralysis

___Other: ICD: _____ Diagnosis: _____

History and Physical Findings Relevant to this Referral: _____

_____

_____

_____

Diagnostic/Test results: _____

_____

_____

_____

Referring Provider's Signature: _____ Print Name: _____

Date: _____ Time: _____ Contact Number: (_____) _____ -_____

OFFICE USE ONLY: Appointment Date: _____/_____/_____ Time: ___:___ am/pm

IF not scheduled, Indicate Reason & Recommendation: _____

_____

Reviewing Provider's Signature: _____ _____Contact Number: (504) 568 -2267