



Mobile Dental Referral Form

FAX referrals to: (504) 903-5313



LSU HEALTH SYSTEM
HEALTH CARE SERVICES DIVISION

TEL: (504) 292-2519 (scheduling and appointments)

(504) 292-2005 (dental questions related to prescriptions, etc)

Email: knels4@lsuhsc.edu

Referral Guidelines

1. To refer a potential client, please complete and fax this two page form. We will not make appointments without a referral sheet, as it must be included in the patient's dental chart.
2. We will contact the client to schedule the appointment (*unless* the client is unable or without a working telephone number, in which case AFTER the referral form is received, we will call the caseworker directly to schedule the appointment with the client).

Note: If a patient is already in a treatment plan at the HOP Dental Clinic/has been seen at HOP dental, we cannot interrupt their treatment plan. **The mobile dental clinic is for persons that haven't had access to dental care in a year or more.**

The mobile dental clinic WILL do evaluations, x-rays, cleanings, extractions (not surgical), and simple fillings. Complicated or cosmetic procedures, i.e. dentures, crowns, root canals, orthodontics, and teeth bleaching/whitening will NOT be done on the mobile dental van. Clients will be referred to Interim LSU Public Hospital Dental Clinic (University Hospital), the LSU School of Dentistry, and HOP where they MAY be charged a fee.

Referring Organization

Org Name/Contact Name: _____ Date: _____

E-Mail Address: _____ Telephone Number: _____

Patient Information

Patient Name: _____

Telephone Number: _____ Date of Birth: _____

Is a Spanish Translator needed? YES _____ NO _____

Latest viral Load _____ Latest CD4 Count _____ (needed for treatment plan, if needed please have patient sign release for medical information)

Patient Appointment Date/Time (Clinic will fill in)

Main Dental Complaint: _____ Allergies/Other: _____

Appt Date: _____ Date Seen: _____

Monday through Thursday, near Tulane Towers, 2601 Tulane Ave. (near NOAIDS Task Force)

LSU Mobile Dental Clinic Authorization to Release Healthcare Information

(Please PRINT.)

Patient's Name: _____ Date of Birth _____

Doctor's Name: _____

Practice Name: _____

Referring Agency: _____

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:

**LSU School of Dentistry Mobile Dental Clinic
1100 Florida Avenue
New Orleans, LA 70119**

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

Health care information released will include the following:

1. History/Physical _____

2. Current medications:

3. Current lab results:

Date labs recorded: _____

CD4 _____ 650-1350

Hct _____ 39-55

Hgb _____ 12-18

Platelet _____ 160-420

Viral Load _____

Hep A _____

Hep B _____

Hep C _____

HIV Diagnosis Date _____

AIDS Diagnosis Date _____

Patient's Signature: _____ Phone: _____

Physician's Name (PRINT)

Physician's Signature

Date