Franciscan Missionaries of Our Lady HEALTH SYSTEM

Request for Results

Telephone: 225-743-2867
Fax: (225) 765-9536

To: _____ From: David Anderson, DO

Fax: _____ Date: _____

Phone: _____

Requesting Provider: David Anderson, DO

Patient: _____ **DOB:** _____

PLEASE INCLUDE THIS FAX FORM WHEN FAXING REPORTS BACK.

If no report available, please let us know also by fax. ( ) No report available.

Please fax patient's most recent:

- ☐ Colonoscopy Report
- ☐ Mammogram
- ☐ Cologuard/FIT Test Report
- ☐ Dexa Scan
- ☐ Diabetic Eye Exam
- ☐ Pap Smear _____ _____

(Signature: Patient or Legal Representative for Pap Smear Only) (Date)

_____

(Description of Relationship if Not the Patient)

By signing I authorize release of information of the requested result(s) to my primary care provider for the purpose of continuation of care.