



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.

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