ACADIANA GASTROENTEROLOGY
ASSOCIATES

439 Heymann Blvd., Lafayette, LA 70503
Ph. (337) 269-0963 * Fax (337) 269-0553

Version08062014

REFERRAL REQUEST FORM

Please Note: The Physicians of AGA, LLC are NOT participating providers of the 'Bayou Health Network'.

Please fax all ***REFERRALS*** for Acadiana Gastroenterology Associates, LLC to: **(337) 269-4662**
Along with this form, please send copies of the following listed below *****. Thank you for your referral.

**** Order * Face-sheet * Insurance Card * List of Current Medications.***

Date: ______________________

Referring To (circle): *Stephen M. Person, MD* / *J. Patrick Herrington, MD* / *James C. Bienvenu, MD*
Richard K. Broussard, MD / *Erick A. Salvatierra, MD* / *Patrick A. Laperouse, MD*
Christopher P. Herrington, MD / *Melanie M. Bienvenu, MD* / or *First Available*

Patient Name: ______________________ **D.O.B.**: ______________________

Patient Phone / Contact Numbers:

Home #: ______________________ *Work #:* ______________________
Mobile #: ______________________ *Other:* ______________________

Insurance: ____

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Referral Type (circle one choice only): OFFICE VISIT or PROCEDURE

Procedure Type (circle): *Colon* *EGD* *ERCP* *EUS* *Dilatation*

Flexible Sigmoidoscopy *Capsule Endoscopy* *Other:* ______________________

Reason For Referral / Procedure: ____

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Referring Physician: ____

Referring Physician Phone #: ____

Name of Nurse Requesting / Sending Referral: ______________________________

*We must have a listing of **Current Medications** for this patient prior to us scheduling a procedure.*
*Please send any recent **Clinical Notes, Labs or Diagnostic Tests** as it pertains to this referral. Thank you.*