Dr. Raj Bhandari

616 S. Washington Street	3424 Medical Park Drive, Ste 6
Bastrop, LA 71220	Monroe, LA 71203
Phone: 318-283-2177	Phone: 318-329-2171
Fax: 318-283-2251/283-1679	Fax: 318-283-2251/283-1679

Date: ___________________________ Referring Physician: _______________________________________

Phone No. ______________________________ Fax: ____

Patient Info: Name of Patient: ____

DOB: _______________________ Preferred Phone No. __________________________cell work home

Name of Insurance Carrier: Primary_______________________ Is pt: ambulatory/ wheelchair/stretcher

FAX COMPLETED FORM WITH THE FOLLOWING INFORMATION(this is a must)

RECENT HISTORY AND PHYSICAL	ABDOMINAL ULTRASOUND	INSURANCE CARD
RECENT COMPLETE LAB RESULTS	MRI/MRA-CT	DEMOGRAPHICS
MEDICATION LIST	RECENT HOSPITALIZATIONS/ER VISITS	

______________________ **If patient Medicaid please send referral. We do not accept Amerigroup**

TYPE OF CONSULT: (Please indicate location of appt, Bastrop or Monroe office) for procedures indicate location as well, MGH, Delhi, WCMH, ECM, MSH

☐ **EGD** ☐ **COLON** ☐ **PEG TUBE PLACEMENT** ☐ **OFFICE CONSULT**
☐ **PEG REPLACEMENT** ☐ **FLEX SIGMOIDOSCOPY**
☐ **OTHER ________________________________ Location: ______________________________________**

NATURE OF CONSULTATION: ROUTINE _______ 30-60 DAYS ________ URGENT _______

(PLEASE CIRCLE) We must have **DIAGNOSIS/SYMPTOMS**: diagnosis circled!!!!!!!

ABNORMAL LIVER FUNCTIONS TEST	+OCCULT BLOOD	DIARRHEA	SCREENING/WELLNESS COLON
ANEMIA	DYSPHAGIA	CONSTIPATION	PHX COLON CANCER
ABDOMINAL PAIN (SPECIFY SITE)	REFLUX	NAUSE/VOMITING	PHX COLON POLYPS
CHANGE IN BOWEL HABITS	HEMATOCHEZIA(RECTAL BLEEDING)		FHX OF COLON CANCER
HEPATITIS C	HEPATITIS B	Other: __________________________________	

******IF THIS FORM IS INCOMPLETE THE OFFICE WILL BE UNABLE TO ASSIGN AN APPOINTMENT******
PLEASE REVIEW THE FORM BEFORE SENDING TO ENSURE COMPLETENESS!

INTERNAL OFFICE USE ONLY

DATE OF CONTACT:	MESSAGE:	DATE SCHEDULED
1.______________	______________________________	_________________________
2. ______________	______________________________	STAFF INITALS:
3. ______________	______________________________	________________

Check computer to see if patient has old chart: _____ if so year: __________ chart requested: ______

Signature of referring physician: ____