The Burden Riehl Center 1211 Coolidge Boulevard Suite 303 Lafayette, LA 70503
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Esophageal motility referral

Please fax completed form, demographics with insurance information, recent office note, and **any previous EGD** to 337-264-6948

Referred by: ____

Diagnosis with diagnosis code: ____

Office Contact: ___________________________ Contact Phone: __________________________

Patient Name: ____ D.O.B.: _______________

Home phone: ______________________ Cell: ____________________ Work: __________________

Primary insurance: ____

Member/Policy ID: ___________________________________ Group#: __________________________

Secondary insurance: ____

Member/Policy ID: ___________________________________ Group#: __________________________