OhioHealth

PATIENT REFERRAL FORM

OhioHealth Physician Group
Urology

Patient information:

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip code: _____

Main Phone#: _____ Alternate phone #: _____ Social Security Number: _____

Birth Date: _____ Language: _____ Interpreter: ☐ Yes ☐ No Special needs: _____

Referring Physician information:

Physician's Printed Name: _____ Physician Signature: _____

Office Phone #: _____ Fax#: _____ Form completed by: _____

Reason for Referral: _____

Diagnosis Code: _____ ***If BWC – Allowed Diagnosis Code:*** _____

☐ **Evaluate and Treat** ☐ **Consultation Only/Second Opinion** ☐ **Other** _____

Insurance Information: **SEND COPY OF INSURANCE CARD - FRONT AND BACK - AND ANY PATIENT RECORDS / REPORTS**

Referral / Authorization/ Claim # _____ Insurance Company: _____ ☐ Self Pay

☐ BWC Employer _____ Date of Injury _____ MCO Name _____

Patient Needs an Appointment: ☐ **ASAP** ☐ **Within one week** ☐ **Patient's Convenience** ☐ **Office to call patient** ☐ **Patient to call office**

☐ Brittany Adamic MD	16	
☐ Eamonn Bahnson MD	1	3
☐ Ilana Bergelson MD	11	17
☐ John Brockman MD	1	2 9
☐ Fadel Elkhairi MD	4	5
☐ Ryan Farrell MD	11	16 17
☐ Eric Fichtenbaum MD	11	17
☐ Jeffrey Harbrecht MD	5	9
☐ George Ho MD	11	17
☐ Jason Jankowski MD	13	14 15
☐ Tariq Khemees MD	1	15
☐ Gregory Knudson MD	6	7
☐ Jennifer Lam MD	2	9
☐ Gregory Lowe MD	1	
☐ Kristin Lowe MD	8	
☐ Bryan Meyerson MD	13	17
☐ Matthew Murtha MD	9	10
☐ Andrew Park MD	15	
☐ Abhishek Patel MD	10	
☐ Raunak Patel MD	5	
☐ Ketul Shah MD	9	10
☐ Andrew Smock MD	10	
☐ Eric Ward MD	1	3 54
☐ Michael Yu MD	11	17

Fax: (614) 533-0177 Phone: (614) 788-2870
1) 500 Thomas Lane Suite 3G Columbus 43214
2) 300 Polaris Parkway Suite 240 Westerville 43082
3) 5150 E. Dublin Granville Rd Suite 220 Columbus 43081
4) 651 W. Marion St Mt Gilead 43338
5) 7450 Hospital Dr, Suite 350 Dublin 43016

Fax: (740) 368-5591 Phone: (740) 368-5550
6) 551 W. Central Ave, Suite 102 Delaware 43015
7) 10190 US Hwy 42 Suite 210D Marysville 43040

Fax: (740) 566-4631 Phone: (740) 566-4630
8) 75 Hospital Drive Suite 250 Athens 45701

Fax: (740) 375-8164 Phone: (740) 383-7950
9) 1050 Delaware Ave Marion 43302

Fax: (614) 544-1853 Phone: (614) 544-1460
10) 4363 All Seasons Drive Suite 240 Hilliard 43026

Fax: (614) 544-9671 Phone: (614) 544-9670
11) 500 E. Main St, Suite 220 Columbus 43215
12) 1450 Davidson Dr Reynoldsburg 43068

Fax: (614) 533-0076 Phone: (380) 243-3113
13) 1010 Refugee Road, Suite 310 Pickerington 43147
14) 625 W Waterloo Street Suite 310B Canal Winchester 43110

Fax: (567) 309-2045 Phone: (567) 309-2040
15) 1020 Cricket Lane Mansfield 44906

Fax: (614) 533-0128 Phone: (614) 544-8104
16) 7450 Hospital Dr, Suite 300 Dublin 43016

Fax: (740) 420-8625 Phone: (740) 420-7882
17) 600 N. Pickaway St, Suite 402 Circleville 43113

Please fax all pertinent records in advance of appointment if not done at OhioHealth. Do not mail reports.

APPOINTMENT INFORMATION: ***Return to referring physician*** Date Scheduled: _____ Time _____

Physician _____ Location _____

Appointment Info back to referring physician ☐ Faxed ☐ New patient packet mailed **Date**: _____ 7/1/2026