

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: _____
 Primary Care Specialty Office Phone #: _____ Fax#: _____ Form completed by: _____

Reason for Referral: _____

Diagnosis Code: _____

Evaluate and Treat Consultation Only/Second Opinion Other _____

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

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

Patient Needs an Appointment: ASAP First Available Provider Routine

<input type="checkbox"/> Divya Akshintala MD <input type="checkbox"/> Zhao Liu MD <input type="checkbox"/> Nandar Mon MD <input type="checkbox"/> Shrikant Tamhane MD Fax: (614) 566-0611 Phone: (614) 566-0610 5150 E Dublin Granville Rd Columbus OH 43081 393 E Town St Suite 115 Columbus OH 43215	<input type="checkbox"/> Hussein Adly MD <input type="checkbox"/> Tori Lowe CNP <input type="checkbox"/> Sarah Taylor CNP <input type="checkbox"/> Zachary Watson CNP Fax: (419) 522-2240 Phone: (419) 522-2734 335 Glessner Ave MOB 3 rd Flr Mansfield OH 44903
<input type="checkbox"/> Sirisha Donepudi MD Fax: (740) 375-8166 Phone: (740) 375-6492 1050 Delaware Ave Marion OH 43302 6 Lexington Blvd Ave Delaware OH 43015	REASON for visit and documentation <u>REQUIRED</u> WITH EACH REFERRAL AND DIAGNOSIS: This practice <u>does not</u> treat patients with the following diagnosis: Transgender patients requiring hormone replacement therapy. <input type="checkbox"/> Diabetes (Gestational Diabetes - Mansfield location only) Progress Notes, All Diabetic labs w/i last year, medication list <input type="checkbox"/> Thyroid Progress Notes, All Thyroid labs w/i last 6 months (MUST include TSH, T4, T3, etc), any imaging w/i last 12 months, medication list <input type="checkbox"/> Osteoporosis Progress Notes, Labs (MUST include Vitamin D & Calcium), imaging and report(s) w/i last 24 months, medication list <input type="checkbox"/> Pituitary Progress Notes, MRI w/I last 12 months (if available), medication list; labs (if available) <input type="checkbox"/> Adrenal Progress Notes, Adrenal Labs (MUST include Potassium & Cortisol), any imaging w/i last 12 months, medication list; labs (if available)
<input type="checkbox"/> Louise Owen MD <input type="checkbox"/> Jay Patel MD <input type="checkbox"/> Brianna Stevens DNP Fax: (614) 788-8361 Phone: (614) 788-8360 5141 W Broad St Suite 180 Columbus OH 43228	
<input type="checkbox"/> Yuanjie Mao MD <input type="checkbox"/> Amber Healy DO (Diabetologist) <input type="checkbox"/> Hollie Goodell RN (DSMT only) Fax: (740) 566-4881 Phone: (740) 566-4880 75 Hospital Drive, Suite 200 Athens OH 45701	
<input type="checkbox"/> Nora Alghothani MD <input type="checkbox"/> Katherine Kendjorsky DO <input type="checkbox"/> Michelle Kovalaske MD <input type="checkbox"/> Amita Maturu MD <input type="checkbox"/> Jillian Pattison DO <input type="checkbox"/> Rundsarah Tahboub MD Fax: (614) 533-4045 Phone: (614) 533-4998 7630 Rivers Edge Drive Columbus OH 43235 1125 Yard Street, Suite 250 Grandview OH 43212	
<input type="checkbox"/> Janki Patel MD <input type="checkbox"/> Shogufa Kamin PA-C Fax: (740) 420-8474 Phone: (740) 420-8581 600 Pickaway St 2 nd Flr Circleville OH 43113	

APPOINTMENT INFORMATION: Date Scheduled: _____ Time _____ Physician _____
 Location _____ Appt Info back to referring physician Faxed New patient packet mailed Date: _____ 4/16/2026