OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

Osteopathic Manipulative Medicine
Acupuncture

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: ______________________

☐ **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

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**

☐ Shawn Kerger DO

FAX: (614) 788-0587 Phone: (614) 788-0588

7450 Hospital Drive Suite 4500 Dublin, OH 43016

☐ Benjamin Booker DO ☐ Jennifer Kingery DO
☐ Stevan Walkowski DO

FAX: (740) 592-7011 Phone: (740) 592-7010

191 W Union Street Suite 127 Athens OH 45701

☐ Andrew Eilerman DO **(ADULT ONLY)** ☐ Frances Comer DO **(PEDS ONLY)**

FAX: (614) 544-0102 Phone: (614) 544-0101

2030 Stringtown Road Suite 300 Grove City OH 43123

PLEASE FAX THE FOLLOWING WITH REFERRAL FORM

☐ X-RAY ☐ CT ☐ MRI ☐ EMG

☐ OTHER TESTING ______________________

☐ OTHER TESTING ______________________

☐ OTHER TESTING ______________________

☐ OTHER TESTING ______________________

☐ OTHER TESTING ______________________

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**:______________ 8/1/2025