OhioHealth

PATIENT REFERRAL FORM

OhioHealth Physician Group

Cancer Surgery

Endocrine Surgery

Surgical Oncology

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 RELATED 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**

Physician Consulted

☐ David Arrese MD
☐ James G. Sivard Jr., MD
☐ Ramy Fouad Fahmy, MD
☐ Stephanie Goare, MD

Fax: (614) 533-0436 **Phone: (614) 566-2370**

500 Thomas Lane Suite – 2C Columbus, OH 43214

What tests have been done:

☐ X-RAY	Date: ________	☐ CT	Date: __________
☐ MRI	Date: ________	☐ EUS	Date: __________
☐ U/S	Date: ________	☐ PET	Date: __________
☐ EGD	Date: ________	☐ CT	Date: __________
☐ LABS	Date: ________		
☐ ________	Date: ________	☐ ___ ___	Date: __________

☐ Other: ____________________

Patients to hand carry any films and reports to their appointment if not done at OhioHealth. Do not mail reports

APPOINTMENT INFORMATION:* *Return to referring physician

Date Scheduled: ______________ Time ______________ Physician ______________

Appointment Info back to referring physician ☐ Faxed ☐ New patient packet mailed **Date**: ______________

3/4/19