OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Behavioral Health

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**

FAX: (567) 241-7719 Phone: (567) 241-7037
770 Balgreen Drive Suite 203 Mansfield OH 44906

FAX: (740) 375-8129 Phone: (740) 383-7910
990 S. Prospect St Suite 3 Marion OH 43302

Transcranial Magnetic Stimulation

FAX: (614) 566-6970 Phone: (614) 566-3388
3820 Olentangy River Rd Columbus OH 43214

Electroconvulsive Therapy

FAX: (614) 566-6666 Phone: (614) 566-4918
3535 Olentangy River Rd Columbus OH 43214

Current Symptoms (i.e.: mood, affect, sleep, appetite):

Past Psych Treatment (inpatient, outpatient and reasons):

Current Psych Meds:

Past Psych Meds & Reason Discontinued:

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

Physician _____ Location _____

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