

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 _____

*If BWC, please attach approved C-9 allowing patient to see specialist

MCO Name _____

Patient Needs an Appointment: ASAP Patient's Convenience Office to call patient Patient to call office

| <input type="checkbox"/> First Available <input type="checkbox"/> Arminster Kaura MD <input type="checkbox"/> Kyle Lineberry MD <input type="checkbox"/> Joseph Minarchek MD <input type="checkbox"/> Wesley Sivak MD PhD Fax: (614) 566-8668 Phone: (614)566-9496 285 E State Street Suite 600 Columbus, OH 43215 | <i>What tests have been done:</i> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Test</th> <th style="text-align: left;">Facility</th> <th style="text-align: left;">Date</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> X-RAY</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> CT</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> MRI</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> EMG</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>**If referring for carpal tunnel: EMG must be completed prior to scheduling visit</p> | Test | Facility | Date | <input type="checkbox"/> X-RAY | _____ | _____ | <input type="checkbox"/> CT | _____ | _____ | <input type="checkbox"/> MRI | _____ | _____ | <input type="checkbox"/> EMG | _____ | _____ | <input type="checkbox"/> Other | _____ | _____ |
|---|---|-------|----------|------|--------------------------------|-------|-------|-----------------------------|-------|-------|------------------------------|-------|-------|------------------------------|-------|-------|--------------------------------|-------|-------|
| Test | Facility | Date | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> X-RAY | _____ | _____ | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> CT | _____ | _____ | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> MRI | _____ | _____ | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> EMG | _____ | _____ | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other | _____ | _____ | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Arthur Kumpf MD <input type="checkbox"/> Leslie Conigy PA Fax: (740) 375-6499 Phone: (740) 375-6498 1. 1040 Delaware Ave Marion OH 43302 2. 6 Lexington Blvd Delaware OH 43015 3. 885 N Sandusky Ave Upper Sandusky OH 43351 | | | | | | | | | | | | | | | | | | | |

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:** _____