OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group

Plastic and Reconstructive Surgery

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**

☐ First Available ☐ Kristopher Katira MD

☐ Arminder Kaura MD ☐ Kyle Lineberry MD

☐ Joseph Minarchek MD ☐ Wesley Sivak MD PhD

Fax: (614) 566-8668 Phone: (614)566-9496

285 E State Street Suite 600 Columbus, OH 43215

☐ Arthur Kumpf MD ☐ Leslie Conigy PA-C

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

What tests have been done:

Test	Facility	Date
☐ X-RAY	_____	_____
☐ CT	_____	_____
☐ MRI	_____	_____
☐ EMG	_____	_____
☐ Other	_____	_____

****If referring for carpal tunnel: EMG must be completed prior to scheduling visit**

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**: _____