

PATIENT SCHEDULING/REFERRAL FORM

**OhioHealth Physician Group
Gynecology**

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

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

<input type="checkbox"/> Jacqueline Rohl MD <input type="checkbox"/> Anita Somani MD <input type="checkbox"/> Shivkamini 'Mini' Somasundaram MD <input type="checkbox"/> Brienne Williford MD <input type="checkbox"/> Jennifer Cartmel CNP <input type="checkbox"/> Laura Merzbacher PA <input type="checkbox"/> Anna Ricks CNP <input type="checkbox"/> Catherine Seyfert CNP <p style="text-align: center;">3600 Olentangy River Rd, Suite A Columbus OH 43214 Fax: (614) 583-5559 Phone: (614) 583-5552</p>	<p><u>What tests have been done:</u></p> <input type="checkbox"/> Gyn U/S <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> X-Ray <input type="checkbox"/> Labs <input type="checkbox"/> Colposcopy <input type="checkbox"/> LEEP <input type="checkbox"/> Hx Abnormal Pap Smear <input type="checkbox"/> Other Testing: _____ <input type="checkbox"/> Other Testing: _____ <input type="checkbox"/> Other Testing: _____ <p>**Please include patient's current medication list**</p>
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If outside of OhioHealth, please fax all pertinent medical records PRIOR to appointment for review. 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: _____ 01/18/2024