

PATIENT REFERRAL FORM
Gerlach Center for Senior 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

- First Available
- Stephanie Garrett MD
- Kathleen Hager DO
- Lakshmi Rangaswamy MD
- Jared Stroud MD, PharmD

FAX: (614) 566-1916 Phone: (614) 566-5858

785 McConnell Drive, Columbus OH 43214

Scheduling Contact Information:

Name: _____

Relationship to Patient: _____

Phone: _____

Use this contact for scheduling purposes

Comments: _____

APPOINTMENT INFORMATION: Return to referring physician

Date Scheduled: _____ Time _____

Physician _____ Location _____

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