OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Maternal/Fetal Medicine Physicians

Patient information:

Patient Name: _____ Date: _____

Address: _____ City: _____ State _____ Zip code: _____

Main Phone#: _____ Alternate phone #: _____

Social Security Number: _____ Birth Date: _____

Language: _____ Interpreter: ☐ Yes ☐ No **EDC: _____ LMP: _____G:_____ P: _____**

Referring Physician information:

Physician's Printed Name: _____ Physician Signature: _____

Office Phone #: _____ Fax#: _____ Form completed by: _____

Reason for Referral: _____

Diagnosis Code: _____

Insurance Information: **SEND COPY OF INSURANCE CARD (FRONT AND BACK) - AND ANY RELATED PATIENT RECORDS / REPORTS**

Referral / Pre-Authorization # _____ Insurance Company: _____ _____Self Pay

Patient Needs an Appointment: ☐ **Urgent – Called MFM** ☐ **First available** ☐ **Within one week** ☐ **Patient to call office**

Preferred Location:

☐ Riverside ☐ Grant

☐ Doctors ☐ Dublin

☐ Licking/Newark

Scheduling Number: (614) 566-4378

Scheduling Fax Number: (614) 533-1216

Ambulatory Referral to Perinatology:

Types:
- ☐ Evaluate & Treat
- ☐ Consult
- ☐ MFM Ultrasound
- ☐ MFM Consult & Ultrasound

Additional MFM Services:
- ☐ MFM Genetic Counseling
- ☐ MFM Non-Stress Test (NST)

MFM Management Type:
- ☐ Co-management
- ☐ Transfer of Care to High Risk OB Clinic
- ☐ Not Applicable

APPOINTMENT INFORMATION: ***Return to referring physician***

Date Scheduled: _____ Arrival Time _____ Location _____

Services Scheduled _____

Appointment Info faxed to referring physician by: _____ Date: _____

5/2/18