OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Ear, Nose & Throat

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 PATIENT RECORDS / REPORTS**

Referral / Authorization/ Claim # ______________ Insurance Company: ______________ ☐ Self Pay

☐ BWC Employer ______________ Date of Injury ______________ MCO Name ______________

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

☐ James Preuter DO ☐ Christopher Selinsky DO

Audiology Only:

☐ Susan LaChance AuD ☐ Abigail Stevens AuD

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1. 5193 W. Broad Street Suite 100 Columbus OH 43228

☐ Eric Grimes MD ☐ Mykola Prykhodko MD

☐ Melinda Henry AuD

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1. 335 Glessner Ave, 5th Floor Mansfield OH 44903
2. 1720 OhioHealth Way Ashland OH 44805

☐ Daniel Wade DO

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Audiology Only:

☐ Julie Bonko AuD ☐ Meredith Kromer-Edward AuD

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☐ Jessica Ball DO ☐ Antonio Collazo MD

☐ Sherrie Stump MA, F-AAA

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1. 990 S. Prospect St, Suite 1 Marion OH 43302
2. 921 E Franklin St, Kenton OH 43326
3. 6 Lexington Blvd, Delaware OH 43015
4. 651 W Marion Rd, Mt Gilead OH 43338

What tests have been done:

Test	Facility	Date
☐ Audiology	______________	__________
☐ __________	______________	__________
☐ __________	______________	__________

☐ OTHER TESTING ______________________

APPOINTMENT INFORMATION: Return to referring physician Date Scheduled: ______________ Time ______________

Physician ______________ Location ______________ 2/5/2026