

**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  Colonoscopy  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 \_\_\_\_\_  
 MCO Name \_\_\_\_\_

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

<input type="checkbox"/> William Main DO <span style="float: right;">1</span> <input type="checkbox"/> M. Krishna Rao MD <span style="float: right;">2</span>  <b>Fax: (614) 533-1213</b> Phone: (614) 864-1000 1) 4882 East Main Street Suite 220 Columbus 43213 2) 285 E. State Street, Suite 150 Columbus 43215	<input type="checkbox"/> Scott Brill MD <span style="float: right;"><input type="checkbox"/> Melinda Jack MD</span> <input type="checkbox"/> M. Krishna Rao MD  <b>Fax: (614) 533-0589</b> Phone: (614) 566-4449 500 Thomas Lane Suite 4A Columbus 43214
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**What tests have been done:**

X-RAY Date: \_\_\_\_\_  CT Date: \_\_\_\_\_  EGD Date: \_\_\_\_\_  CT Date: \_\_\_\_\_  
 MRI Date: \_\_\_\_\_  EUS Date: \_\_\_\_\_  LABS Date: \_\_\_\_\_  \_\_\_\_\_ Date: \_\_\_\_\_  
 U/S Date: \_\_\_\_\_  PET Date: \_\_\_\_\_

**\*\*Consultations for Cancer, Crohn's disease, Diverticulitis, Polyps, Mass or Ulcerative Colitis require the patient medical records at time of visit\*\***

**APPOINTMENT INFORMATION: Return to referring physician** Date Scheduled: \_\_\_\_\_ Time \_\_\_\_\_

Physician \_\_\_\_\_ Location \_\_\_\_\_

**Appointment Info back to referring physician**  Faxed  New patient packet mailed **Date:** \_\_\_\_\_ 4/16/2026