OhioHealth

PATIENT REFERRAL FORM

OhioHealth 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

☐ 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**

☐ First Available

☐ Kathleen Hager DO

☐ Kim Jordan MD

☐ Meredith Mucha MD

☐ Lakshmi Rangaswamy MD

☐ Marian Schuda MD

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

3830 Olentangy River Road, Columbus OH 43214

☐ Comprehensive Geriatric Assessment (consult)

Alternate 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**: _____

3/8/18