

## PATIENT SCHEDULING/REFERRAL FORM

### OhioHealth Physician Group Infectious Diseases

**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

<input type="checkbox"/> Megan Buller MD <input type="checkbox"/> Christian Greco DO <input type="checkbox"/> Rhidima Monga MD <input type="checkbox"/> Wissam Sabbagh MD <input type="checkbox"/> Gina Zilioli MD <input type="checkbox"/> April Isaac-Vachio CNP <input type="checkbox"/> Morgan Osam-Duodo PA-C <input type="checkbox"/> Jason Tagliarina CNP  <p style="text-align: center;"><b>FAX: (614) 788-5210    Phone: (614) 788-5200</b>          3555 Olentangy River Road, Suite 3000 Columbus, OH 43214</p>	<input type="checkbox"/> Prity Vaidya MD  <p style="text-align: center;"><b>FAX: (419) 526-8854    Phone: (419) 526-8044</b>          295 Glessner Ave Mansfield OH 44903</p> <hr/> <p style="text-align: center;"><b>PLEASE FAX THE FOLLOWING WITH REFERRAL FORM</b></p> <p>___ Recent Progress Notes          ___ Recent Labs          ___ Current Medication List          ___ Other pertinent medical records</p>
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**APPOINTMENT INFORMATION: Return to referring physician**

Date Scheduled: \_\_\_\_\_ Time \_\_\_\_\_  
 Physician \_\_\_\_\_ Location \_\_\_\_\_  
**Appointment Info back to referring physician**     Faxed     New patient packet mailed    **Date:** \_\_\_\_\_    3/17/2023