

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"/> First Available OR <input type="checkbox"/> Physician Requested: _____ Location: _____ Fax: _____ (list of physicians & locations on next page) | <p style="text-align: center;">PLEASE FAX THE FOLLOWING WITH REFERRAL FORM</p> <input type="checkbox"/> X-RAY <input type="checkbox"/> CT <input type="checkbox"/> U/S <input type="checkbox"/> MRI <input type="checkbox"/> EGD <input type="checkbox"/> LABS <input type="checkbox"/> OTHER TESTING _____ <input type="checkbox"/> OTHER TESTING _____ <input type="checkbox"/> OTHER TESTING _____ <p style="text-align: center;">**Please include patient's current medical list**</p> |
|---|---|

Patients to hand carry any films and reports to their appointment if not done at OhioHealth. Do not mail reports

APPOINTMENT INFORMATION: Return to referring physician

Date Scheduled: _____ Time _____

Physician _____ Location _____

Appointment Info back to referring physician Faxed New patient packet mailed **Date:** _____

PATIENT REFERRAL FORM

- Thomas Sonnanstine MD** (Bariatrics) 1
- Nirav Rana MD** (Bariatrics) 1
- T. Calloway Robertson MD** (Bariatrics) 1

FAX: (614) 566-1212 Phone: (614) 566-3946
 1. 3773 Olentangy River Rd – Lower Level Columbus OH 43214

- Richard Costin DO** 1
- James Massullo MD** 1
- Donald Hura MD** 1 2
- Alyssa Pastorino DO** 1 3

FAX: (614) 544-1087 Phone: (614) 544-1880
 1. 5131 Beacon Hill Rd Suite 220 Columbus OH 43228
 2. 1076 Eagleton Blvd Suite C London OH 43140
 3. 4343 All Seasons Dr, Suite 100 Hilliard OH 43026

- Joshua Braveman MD** (Colon & Rectal) 1 3 7
- Albert Campbell MD** 1 3 5
- Mark Jump DO** 1 2 4
- Kristin Ryan DO** (Surgical Oncology) 1 3 7
- Grace Lee MD** (Endocrine) 1 6

FAX: (614) 566-7488 Phone: (614) 566-7444
 1. 285 E. State St Suite 640 Columbus OH 43215
 2. 765 N. Hamilton Rd Suite 235 Gahanna OH 43230
 3. 1010 Refugee Rd Suite 310 Pickerington OH 43147
 4. 2030 Stringtown Rd Suite 210 Grove City OH 43123
 5. 6024 Hoover Rd Suite F Grove City OH 43123
 6. 11925 Lithopolis Rd Canal Winchester OH 43110
 7. 300 Polarisk Pkwy Suite 1050 Westerville OH 43082

- Jeffrey Archer MD** 1
- Laura Avery MD** 1
- Daniel Detrich MD** 1
- Robert Maxwell MD** 1
- Elwood Martin MD** 1
- Piyush Sheth MD** 1

FAX: (419) 524-1619 Phone: (419) 522-2833
 1. 335 Glessner Ave 5th Floor Mansfield OH 44903

- Raymond Fuller MD** 1 2
- Kenneth Graffeo MD** 1 2
- Michelle Wood DO** 1 2

FAX: (740) 615-0462 Phone: (740) 615-0450
 1. 90 E. William St Delaware OH 43015

FAX: (419) 949-3135 Phone: (419) 949-3073
 2. 651 W. Marion Rd Mt. Gilead OH 43338

- William Schirmer MD** 1

FAX: (740) 615-0359 Phone: (740) 615-0350
 1. 551 W. Central Ave Suite 303 Delaware OH 43015