OhioHealth

PATIENT REFERRAL FORM

OhioHealth Physician Group
Cancer Surgery
Endocrine Surgery
Surgical Oncology

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**

Physician Consulted

- ☐ David Arrese MD
- ☐ Ramy Fouad Fahmy MD
- ☐ Stephanie Goare MD
- ☐ Patrick Salibi MD
- ☐ Alexandra Wells MD

Fax: (614) 533-0436 Phone: (614) 566-2370

500 Thomas Lane, Suite 2C Columbus OH 43214

1010 Refugee Road, Suite 1000 Pickerington OH 43147

What tests have been done:

- ☐ X-RAY Date: _____ ☐ CT Date: _____
- ☐ MRI Date: _____ ☐ EUS Date: _____
- ☐ U/S Date: _____ ☐ PET Date: _____
- ☐ EGD Date: _____ ☐ CT Date: _____
- ☐ LABS Date: _____
- ☐ _____ Date: _____ ☐ ___ ___ Date: _____
- ☐ Other: _____

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 _____

Appointment Info back to referring physician ☐ Faxed ☐ New patient packet mailed **Date**: _____ 9/18/2025