

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"/> Shruti Kapoor MD Fax: (614) 788-4459 Phone: (614) 788-4440 3663 Ridge Mill Dr Suite 100 Hilliard OH 43026 5150 E Dublin-Granville Rd Suite 210 Westerville OH 43081	Is the patient on long-term opiate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Jason Allen DO Fax: (614) 533-1770 Phone: (740) 566-4750 265 West Union St, Suite B Athens OH 45701	The patient has: <input type="checkbox"/> exhibited drug seeking behavior <input type="checkbox"/> been non-compliant with opioid therapy in the past <input type="checkbox"/> demonstrated accelerated medication use or misplaced controlled medications <input type="checkbox"/> been discharged from another pain practice <input type="checkbox"/> raised concerns about opioid misuse, abuse or addiction <input type="checkbox"/> none
<input type="checkbox"/> Jamesetta Lewis MD Fax: (740) 375-8180 Phone: (740) 383-7747 1040 Delaware Ave Marion OH 43302	Physician Signature _____ Date _____ *Physicians do not write prescriptions for controlled substances on initial visit
<u>What tests have been done:</u> <input type="checkbox"/> X-RAY Date: _____ <input type="checkbox"/> CT Date: _____ <input type="checkbox"/> MRI Date: _____ <input type="checkbox"/> EMG Date: _____ <input type="checkbox"/> _____ Date: _____ <input type="checkbox"/> _____ Date: _____	If outside of OhioHealth, please fax all pertinent medical records PRIOR to appointment for review. 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:** _____ 9/19/2025