OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Podiatry

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**

☐ Earl Driggs DPM ☐ Alex Pilkinton DPM

Fax: (740) 594-8925 Phone: (740) 592-5799

75 Hospital Drive Suite 340 Athens 45701

1319 W Hunter Street Logan 43138

☐ William Springer DPM

FAX: (740) 382-9125 Phone (740) 383-7099

1050 Delaware Ave Marion 43302

801 OhioHealth Blvd Suite 140 Delaware 43015

921 E. Franklin St Kenton 43326

☐ CJ Hassmann DPM

FAX: (614) 533-0710 Phone (567) 241-7930

231 East Main Street Lexington 44904

335 Glessner Avenue, 2nd Floor Mansfield 44906

☐ Jeremiah Dillon DPM ☐ Dina Keeler DPM

☐ Brian Zimmerman DPM ☐ Gabi Domka CNP

FAX: (419) 774-9145 Phone (419) 756-1961

550 S. Trimble Road Mansfield 44906

FAX: (419) 281-4219 Phone (419) 281-3668

45 Amberwood Parkway Ashland 44805

PLEASE FAX THE FOLLOWING WITH REFERRAL FORM

☐ X-RAY ☐ CT ☐ MRI ☐ EMG

☐ OTHER TESTING _____

☐ OTHER TESTING _____

☐ OTHER TESTING _____

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**: _____ 9/27/2024