OhioHealth

# *PATIENT SCHEDULING/REFERRAL FORM*

## OhioHealth Physician Group
## Ear, Nose & Throat

***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 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**

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☐ Christopher Selinsky DO
Audiology Only:
☐ Susan LaChance AuD ☐ Abigail Wills AuD

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***What tests have been done:***

| Test | Facility | Date |
|---|---|---|
| ☐ Audiology | _____ | _____ |
| ☐ _____ | _____ | _____ |
| ☐ _____ | _____ | _____ |
| ☐ _____ | _____ | _____ |
| ☐ _____ | _____ | _____ |

☐ OTHER TESTING _____

***APPOINTMENT INFORMATION:*** ***Return to referring physician***

Date Scheduled: _____ Time _____

Physician _____ Location _____

**Appointment Info back to referring physician** ☐ Faxed ☐ New patient packet mailed **Date**: _____ 8/15/19