

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

<p>Physician Consulted <input type="checkbox"/> First Available</p> <p><input type="checkbox"/> Corinne Calo DO <input type="checkbox"/> Aine Clements MD <input type="checkbox"/> Amy Harper MD <input type="checkbox"/> Kellie Rath MD <input type="checkbox"/> Stuart Pierce MD</p> <p>Fax: (614) 566-1165 Phone: (614) 566-1150</p> <p>1. 500 Thomas Lane – Suite 4B Columbus OH 43214 2. 6700 Perimeter Drive, Suite 210 Dublin OH 43016 3. 340 E Town Street Suite 700 Columbus OH 43215</p>	<p><u>What tests have been done:</u></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Test</th> <th style="text-align: left; border-bottom: 1px solid black;">Facility</th> <th style="text-align: left; border-bottom: 1px solid black;">Date</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p><input type="checkbox"/> OTHER TESTING _____</p> <p><u>REFERRING PHYSICIAN to mail all pathology slides to our office if not done at Ohio Health.</u></p>	Test	Facility	Date	<input type="checkbox"/> _____	_____	_____	<input type="checkbox"/> _____	_____	_____	<input type="checkbox"/> _____	_____	_____
Test	Facility	Date											
<input type="checkbox"/> _____	_____	_____											
<input type="checkbox"/> _____	_____	_____											
<input type="checkbox"/> _____	_____	_____											

APPOINTMENT INFORMATION: Return to referring physician

Date Scheduled: _____ Time _____
 Physician _____ Location _____
Appointment Info back to referring physician Faxed New patient packet mailed Date: _____