

**OhioHealth Physician Group
Breast & Cancer Surgery**
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: _____

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 # _____ Insurance Company: _____ Self Pay

Patient Needs an Appointment: ASAP Within one week Patient's Convenience Office to call patient Patient to call office

<p><u>Physician Consulted</u></p> <p><input type="checkbox"/> Natalie Jones MD</p> <p><input type="checkbox"/> Deepa Halaharvi DO</p> <p><input type="checkbox"/> Jodi Oostra MD</p> <p>FAX: (614) 533-0124</p> <p>1. 500 Thomas Lane Suite 2B Columbus 43214 2. 6700 Perimeter Dr Suite 200 Dublin 43016</p>	<p><u>Circle location preference</u></p> <p>1 2</p> <p>1</p> <p>1 2</p> <p>Phone (614) 566-2280</p>
<p><u>Physician Consulted</u></p> <p><input type="checkbox"/> Mark Cripe DO</p> <p><input type="checkbox"/> Deepa Halaharvi DO</p> <p><input type="checkbox"/> Kara Rossfeld MD</p> <p>FAX: (614) 533-0438</p> <p>1. 285 E State Street Suite 300 Columbus 43215 2. 6700 Perimeter Dr Suite 200 Dublin 43016 3. 1010 Refugee Rd Suite 1000 Pickerington 43147 4. 300 Polaris Pkwy Suite 300 Westerville 43082</p>	<p><u>Circle location preference</u></p> <p>1 2</p> <p>1</p> <p>1 3 4</p> <p>Phone: (614) 566-0774</p>

Mark Area of Concern

Abnormal imaging right left bilateral

Breast lump right left bilateral

Breast Pain right left bilateral

Nipple Discharge right left bilateral

Cancer right left bilateral

High Risk

Melanoma

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: _____ 11/13/2025