PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Robotic Urologic Surgeon

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**

Physician Consulted

Ronney Abaza M.D.

Fax Referral Form to: (614) 533-0128

Phone: (614) 544-8104

7450 Hospital Dr. - Suite 300 Dublin, Ohio 43016

What tests have been done:

	Test	Facility	Date
☐ Pathology:	________	________	____
☐ Imaging:	________	________	____
☐ Labs:	________	________	____
☐ Other:	________	________	____
☐ Other:	________	________	____

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**: __________________

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