OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Liver Care

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: _____

Referring Provider Specialty: _____ ***Diagnosis and Code:*** _____

☐ **Evaluate and Treat** ☐ **Consultation Only/Second Opinion**

Insurance Information: **SEND COPY OF INSURANCE CARD (FRONT AND BACK) - AND ANY RELATED PATIENT RECORDS / REPORTS**

Referral / Authorization/ Claim # _____ Insurance Company: _____ ☐ Self Pay

MCO Name (if applicable) _____

Is this referral URGENT? ☐ **YES** ☐ **NO**

☐ First Available

☐ Ruchi Bhatia MD
☐ James Hanje MD, FAASLD
☐ Anthony Michaels MD
☐ Pranav Penninti DO

☐ Gretchen Calhoun CNP
☐ Pam Kibbe CNP

*Scheduling may occur with another provider in the group based on diagnosis, complexity, or access.

Fax: (614) 566-5151 Phone: (614) 566-5150

3555 Olentangy River Rd, Suite 3010 Columbus OH 43214

REQUIRED - PLEASE SELECT REASON FOR REFERRAL:

☐ Advanced Liver Disease ☐ General Hepatology
☐ Fatty Liver Disease ☐ Hepatitis C – Establish Care
☐ Liver Tumor ☐ Other _____

MEDICAL HISTORY: Does patient currently have or have a history of:

☐ Cirrhosis ☐ Liver Biopsy ☐ Paracentesis

Allergies:

_____

***REQUIRED WITH REFERRAL (if completed)*:**

☐ Abdominal Imaging (MRI, CT, US)
☐ History & Physical
☐ Labs
☐ Medication List
☐ EGD & Colonoscopy Report/Pathology
☐ Liver Biopsy Pathology

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