PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Pulmonary Medicine

Patient information:

Patient Name: ______________________ Date: ______________________

Address: ______________________ City: ______________ State: ______ Zip code: __________

Main Phone#: ______________ Alternate phone #: ______________ Special Needs: ______________

Social Security Number: ______________ Birth Date: __________ Language: ______________ Interpreter: ☐ Yes ☐ No

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: ☐ **Urgent** ☐ **Routine** ☐ **Office to call patient** ☐ **Patient to call office**

☐ Peter Bachwich MD ☐ Amy Lee MD
☐ Susan Borchers MD ☐ pulmonary / ☐ sleep*
☐ Lindsey Hoosic CNP

FAX: (614) 533-0446 Phone: (614) 533-4999
7630 Rivers Edge Drive Columbus, OH 43235
**additional locations available, scheduler will assist*

☐ Lana Alghothani MD ☐ Kiran Devulapally MD
☐ LeRoy Essig II MD ☐ Bradley Harrold MD
☐ Shiva Rahmanian MD ☐ Brenton Riscili MD
☐ Karen L Wood MD

FAX: (614) 566-8080 Phone: (614) 566-9143
111 S. Grant Ave Suite 208, Columbus OH 43215

☐ Joel Provenzano MD ☐ Aileen Ruffino DO
☐ Hiten Shah MD ☐ pulmonary / ☐ sleep*

FAX: (740) 375-6468 Phone: (740) 375-8135
1040 Delaware Avenue, Marion OH 43302
**additional locations available, scheduler will assist*

☐ Elizabeth Brown MD

FAX: (419) 522-0350 Phone: (419) 522-0320
770 Balgreen Dr Suite 107, Mansfield OH 44906

☐ Thomas Burke MD

FAX: (740) 420-8530 Phone: (740) 420-8526
600 N. Pickaway Street Circleville OH 43113

*****For non-OhioHealth radiology testing,* ***PLEASE MAIL*** *a film CD* ***PRIOR*** *to appointment*****

PLEASE FAX THE FOLLOWING WITH REFERRAL FORM

	DATE	LOCATION
Chest X-Ray	________	____________
Chest CT	________	____________
Pulm Function Test	________	____________
Recent Labs	________	____________
Recent Progress Notes	________	____________
Previous Sleep Studies	________	____________
Other pertinent testing	________	____________

Vaccinations:

Pneumovax (PPSV23)	________
Prevnar 13 (PCV13)	________
Influenza	________

All referrals will be considered routine without a physician to physician call

APPOINTMENT INFORMATION: ***Return to referring physician*** Date Scheduled: ______________________ Time ______________

Physician ______________________ Location ______________________

Appointment Info back to referring physician ☐ Faxed ☐ New patient packet mailed **Date:** ______________________ 7/2/19