OhioHealth

PATIENT REFERRAL FORM

OhioHealth Physician Group
Medical Oncology
Hematology

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 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**

☐ Arun Kumar MD ☐ Chaoyang Li MD

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What tests have been done:

☐ X-RAY	Date: _____	☐ CT	Date: _____
☐ MRI	Date: _____	☐ EUS	Date: _____
☐ U/S	Date: _____	☐ PET	Date: _____
☐ EGD	Date: _____	☐ LABS	Date: _____
☐ _____	Date: _____	☐ _____	Date: _____

If outside of OhioHealth, please fax all pertinent medical records PRIOR to appointment for review. 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**: _____ 7/8/19