PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Arthritis and Osteoporosis Physicians

(formerly- Grant Arthritis and Osteoporosis Center)

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**

	Physician consulted	Circle location preference	
☐	Seth Kantor MD (Rheumatology)	1	2
☐	Heather Lake DO (Rheumatology)	1	3
☐	Eric Lirio MD (Rheumatology)	1	

Fax Referral Form to: (614) 566-8175

Phone: (614)566-9380

1. 285 E State Street - Suite 620 Columbus, OH 43215
2. 300 Polaris Parkway – Suite 2150 Westerville, Oh 43081
3. 4882 E Main Street – Suite 120 Columbus, Oh 43213

What tests have been done:

Test	Facility	Date
☐ X-RAY	________________	__________
☐ CT	________________	__________
☐ MRI	________________	__________
☐ EMG	________________	__________

☐ OTHER TESTING ______________________

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**: ______________

3007273 12/30/2015