OhioHealth

PATIENT REFERRAL FORM

OhioHealth Physician Group
Radiation Oncology

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: ☐ **ASAP** ☐ **Within one week** ☐ **Patient's Convenience** ☐ **Office to call patient** ☐ **Patient to call office**

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What tests have been done:

Test	Date	Test	Date
☐ 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**: ______________

7/2/19