

## PATIENT SCHEDULING/REFERRAL FORM

**OhioHealth Physician Group  
Gastroenterology**

**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

<input type="checkbox"/> Akeek Bhatt MD <input type="checkbox"/> Prasad Maturu MD <b>Fax: (740) 383-7051</b> Phone: (740) 692-4477 1050 Delaware Avenue Marion OH 43302	<p><b><u>PROCEDURE REQUESTED:</u></b></p> <input type="checkbox"/> Diagnostic Colonoscopy <input type="checkbox"/> Screening Colonoscopy <input type="checkbox"/> EGD <input type="checkbox"/> PillCam (capsule endoscopy) <input type="checkbox"/> Bravo Endoscopy
<input type="checkbox"/> Ravindra Malholtra MD <input type="checkbox"/> Charity Hellman CNP <b>Fax: (419) 522-2308</b> Phone: (419) 522-2031 1070 Cricket Lane Mansfield OH 44906	<p><b><u>MEDICAL HISTORY:</u> Does patient currently have or have a history of:</b></p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney Disease/Failure <input type="checkbox"/> Heart Disease
<input type="checkbox"/> John Castor MD <input type="checkbox"/> Adil Faqih MD <input type="checkbox"/> Matthew Harbrecht MD <input type="checkbox"/> Andrea Johnson MD <input type="checkbox"/> Poorima Oruganti MD <input type="checkbox"/> Kasey Parker MD <input type="checkbox"/> Brett Slesman MD <input type="checkbox"/> Alok Tripathi MD <input type="checkbox"/> Scott Young MD	<p>Allergies _____</p> <p>Ht: _____ Wt: _____ Sleep Apnea Y / N C-Pap Machine used Y / N</p> <p>.....</p> <p><b><u>REQUIRED WITH REFERRAL:</u> recent x-rays, labs, progress note, H/P and medication sheet</b></p>
<p><b><u>APPOINTMENT INFORMATION:</u> Return to referring physician</b> Date Scheduled: _____ Time _____</p> <p>Physician _____ Location _____</p> <p><b>Appointment Info back to referring physician</b> <input type="checkbox"/> Faxed <input type="checkbox"/> New patient packet mailed <b>Date:</b> _____ 2/7/2025</p>	