OhioHealth

PATIENT REFERRAL FORM

OhioHealth Physician Group
Colon & Rectal Surgery

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** ☐ **Colonoscopy** ☐ **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**

Fax: (614) 533-1213 Phone: (614) 864-1000

☐ Bruce Kerner MD 1 4 ☐ Peter Lee MD 1 2 3

☐ Melinda Jack MD 1 2 ☐ William Main DO 1

1. 4882 East Main Street Suite 220 Columbus, OH 43213
2. 500 Thomas Lane Suite 4A Columbus, OH 43214
3. 1010 Refugee Rd 3rd floor Pickerington, OH 43147
4. 2030 Stringtown Rd Suite 210 Grove City, OH 43123

Fax: (614) 533-0589 Phone: (614) 566-4449

☐ William Wise Jr MD ☐ Scott Brill MD

500 Thomas Lane Suite 4A Columbus, OH 43214

What tests have been done:

☐ X-RAY Date: ________ ☐ CT Date: __________ ☐ EGD Date: ________ ☐ CT Date: __________

☐ MRI Date: ________ ☐ EUS Date: __________ ☐ LABS Date: ________ ☐ ________ Date: ________

☐ U/S Date: ________ ☐ PET Date: __________

****Consultations for Cancer, Crohn's disease, Diverticulitis, Polyps, Mass or Ulcerative Colitis require the patient medical records at time of visit****

***APPOINTMENT INFORMATION:** Return to referring physician*

Date Scheduled: ______________________ Time ______________________

Physician ______________________ Location ______________________

Appointment Info back to referring physician ☐ Faxed ☐ New patient packet mailed **Date:** ______________

10/5/18