OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Rheumatology

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: ☐ **Urgent** ☐ **Routine** ☐ **Office to call patient** ☐ **Patient to call office**

☐ Heather Lake DO	1	3	
☐ Eric Lirio MD	1	2	4
☐ Tanisha Mathur MD	1	2	7
☐ Timothy Underwood MD	1	5	6

FAX: (614) 788-5089 Phone: (614) 788-5000

1. 303 E Town Street, 3rd Floor — Columbus 43215
2. 300 Polaris Parkway, Suite 2150 — Westerville 43081
3. 4882 E Main Street, Suite 120 — Columbus 43213
4. 1010 Refugee Road, Suite 310 — Pickerington 43147
5. 5141 W Broad Street, Suite 150 — Columbus 43228
6. 2030 Stringtown Road, Suite 200 — Grove City 43123
7. 5150 W Dublin-Granville Road Suite 150 — Columbus 43081

☐ Anna Falls DO

FAX: (419) 756-6004 Phone: (419) 756-8899

335 Glessner Ave, 2nd Flr Mansfield 44903

☐ Madhu Mehta MD

FAX: (740) 383-7023 Phone: (740) 383-7820

1050 Delaware Avenue Marion 43302
6 Lexington Blvd Delaware 43015

*****For non-OhioHealth radiology testing,* ***PLEASE MAIL*** *a film CD* ***PRIOR*** *to appointment*****

PLEASE FAX THE FOLLOWING WITH REFERRAL FORM

Test	Facility	Date
☐ X-RAY	______________	__________
☐ CT	______________	__________
☐ MRI	______________	__________
☐ EMG	______________	__________
☐ OTHER TESTING	______________	
☐ OTHER TESTING	______________	

APPOINTMENT INFORMATION: Physician ______________ Location ______________ 4/16/2026

Return to referring physician Date Scheduled: ____________ Time ________ ☐ Faxed ☐ New patient packet mailed **Date**: ________