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**

☐ **Riverside** 3535 Olentangy River Rd, Columbus OH 43214
Fax: (614) 566-6844 Phone: (614) 566-5560

☐ **Grant** 303 East Town Street, Columbus OH 43215
Fax: (614) 566-8224 Phone: (614) 566-9506

☐ **Doctors** 5200 W. Broad Street Columbus OH 43228
Fax: (614) 544-1928 Phone: (614) 544-1930

☐ **Grady** 801 OhioHealth Boulevard Delaware OH 43015
Fax: (740) 615-0255 Phone: (740) 615-0227

☐ **Dublin** 7450 Hospital Drive Suite 160, Dublin OH 43016
Fax: (614) 544-8770 Phone: (614) 544-8900

☐ **Marion** 1000 McKinley Park Drive Marion OH 43302
Fax: (740) 387-2275 Phone: (740) 375-6080

☐ **Mansfield** 330 Glessner Ave Mansfield OH 44903
Fax: (419) 526-8198 Phone: (419) 526-8622

☐ **O'Bleness** 75 Hospital Drive Suite 170, Athens OH 45701
Fax: (740) 331-7072 Phone: (740) 331-7085

☐ **Westerville** 300 Polaris Pkwy Suite 110 Westerville OH 43082
Fax: (614) 788-3332 Phone: (614 788-3333

Requested Physician (if known):

_____

Has patient received prior radiation treatment?

☐ Yes ☐ No ☐ Unsure

If yes, please indicate where treatment was received:

_____

Does patient have cardiac device installed?

☐ Yes ☐ No ☐ Unsure

Has prior testing been completed? ☐ Yes ☐ No

Date completed: _____

If outside of OhioHealth, please list where testing was completed:

_____

_____

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 _____ Location _____

Appointment Info back to referring physician ☐ Faxed ☐ New patient packet mailed **Date**: _____ 4/16/2026