

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group Obstetrics & Gynecology

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

Patient Needs an Appointment: ASAP Within one week Patient's Convenience Office to call patient Patient to call office

<input type="checkbox"/> Dana Moulton MD <input type="checkbox"/> Ngozi Osuagwu MD <input type="checkbox"/> Jennifer Papp DO <input type="checkbox"/> Victoria Powis DO <input type="checkbox"/> Diana Topolnycky DO <input type="checkbox"/> Rhyan Williams CNP 5300 Nike Drive Hilliard, OH 43026 Fax: (614) 777-9032 Phone: (614) 777-5853	<input type="checkbox"/> James Bazzoli MD <input type="checkbox"/> Rebecca Crockett DO <input type="checkbox"/> Deborah Burns, CNM <input type="checkbox"/> Nichole Runyon, FNP 1040 Delaware Ave Marion OH 43302 Fax: (740) 383-8084 Phone: (740) 383-8080
<input type="checkbox"/> Yelena Feldman DO <input type="checkbox"/> Steven Miller DO <input type="checkbox"/> Funmi Kasali MD <input type="checkbox"/> John Parker MD 1. 4191 Kelnor Drive, Suite 300 Grove City OH 43123 2. 5193 W. Broad St., Suite 200 Columbus OH 43228 Fax: (614) 878-7005 Phone: (614) 788-3700	<input type="checkbox"/> Bradley Campbell MD 1073 Harding Memorial Suite B Marion OH 43302 Fax: (740) 387-2278 Phone: (740) 387-2276
<input type="checkbox"/> Era Gupta MD <input type="checkbox"/> Suzanne Lin DO <input type="checkbox"/> William Hammett MD <input type="checkbox"/> Hariklia Louvakis MD <input type="checkbox"/> Elizabeth Koffler MD <input type="checkbox"/> Benjamin Winfree MD 1. 460 W Central Ave, Suite D Delaware OH 43015 2. 7853 Pacer Dr, Suite 3D Delaware OH 43015 Fax: (740) 615-2701 Phone: (740) 615-2700	<input type="checkbox"/> Kathleen Bertuna DO <input type="checkbox"/> Jody Gerome DO <input type="checkbox"/> Jane Broecker MD <input type="checkbox"/> Timothy Kermode DO <input type="checkbox"/> Lucy Bucher DO <input type="checkbox"/> Jack Ramey DO <input type="checkbox"/> Michael Clark DO 1. Castrop Center 75 Hospital Dr, Suite 260 Athens OH 45701 2. 1319 W Hunter St Logan OH 43138 Fax: (740) 594-4099 Phone: (740) 594-8819

APPOINTMENT INFORMATION: Return to referring physician

Date Scheduled: _____ Time _____
 Physician _____ Location _____

Appointment Info back to referring physician
 Faxed
 New patient packet mailed
 Date: _____ 8/15/19