

PATIENT REFERRAL FORM
**OhioHealth Physician Group
Robotic Urologic and Cancer 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 Other _____

Insurance Information: SEND COPY OF INSURANCE CARD - FRONT AND BACK - AND ANY 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"/> Brittany Adamic MD Fax: (614) 533-0128 Phone: (614) 544-8104 7450 Hospital Drive, Suite 300 Dublin, Ohio 43016	<u>What tests have been done:</u> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">Test</th> <th style="text-align: center; border-bottom: 1px solid black;">Facility</th> <th style="text-align: center; border-bottom: 1px solid black;">Date</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Pathology: _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Imaging: _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Labs: _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Test	Facility	Date	<input type="checkbox"/> Pathology: _____	_____	_____	<input type="checkbox"/> Imaging: _____	_____	_____	<input type="checkbox"/> Labs: _____	_____	_____	<input type="checkbox"/> Other: _____	_____	_____	<input type="checkbox"/> Other: _____	_____	_____
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<input type="checkbox"/> Eric Fichtenbaum MD Fax: (614) 544-9671 Phone: (614) 544-9670 500 E Main Street, Suite 220 Columbus OH 43215																			

Patients to hand carry any films and reports to their appointment if not done at OhioHealth. Do not mail reports

APPOINTMENT INFORMATION: Return to referring physician

Date Scheduled: _____ Time _____
 Physician _____ Location _____

Appointment Info back to referring physician Faxed New patient packet mailed **Date:** _____ 9/27/2024