OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Sports Medicine
Primary Care

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

☐ 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**

Physician consulted _____

Preferred location_____

FAX # _____

Listing of physicians, locations and FAX numbers

on back of form

What tests have been done:

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

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**: _____

8/15/19

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Physicians

Sports & Family Medicine	***Circle location***
☐ Benjamin Ahrens DO	6
☐ Monique Brady MD	2
☐ Darrin Bright MD	8
☐ Ken Cayce MD	4
☐ Natalie Dick DO	4
☐ Jason Diehl MD	5
☐ Kristen Dimitris MD	3
☐ Douglas DiOrio MD	1
☐ Anthony Ewald MD	3
☐ Craig Fortman DO	9
☐ John Hedge DO	1
☐ Thomas Hospel MD	5
☐ Donald LeMay DO	2
☐ Austen Musick DO	6
☐ Joel Shaw, MD	7
☐ Robert Sickles MD	5
☐ Ryan Siegel DO	2
☐ Vismai Sinha MD	1
☐ Marguerite Weston MD	3

Locations

1. 3705 Olentangy River Road, Suite 260 Columbus, OH 43214
   Fax: (614) 533-6609 Phone: (614) 533-6600
2. 1010 Refugee Road, Suite 200 Pickerington, OH 43147
   Fax: (614) 788-4222 Phone: (614) 788-4232
3. 300 Polaris Parkway, Suite 2150 Westerville, OH 43082
   Fax: (614) 533-3289 Phone: (614) 533-3280
4. 801 OhioHealth Blvd, Suite 200 Delaware, OH 43015
   Fax: (740) 615-0279 Phone: (740) 615-0270
5. 6955 Hospital Drive Dublin, OH 43016
   Fax: (614) 566-1429 Phone: (614) 566-1420
6. 4343 All Seasons Drive, Suite 100 Hilliard, OH 43026
   Fax: (614) 544-1156 Phone: (614) 544-1155
7. 303 E. Town St, 2nd Floor Columbus OH 43215
   Fax: (614) 533-6609 Phone: (614) 533-6600
8. 5868 N. Hamilton Rd, 2nd Flr Columbus, OH 43230
   Fax: (614) 788-9406 Phone: (614) 533-6600
9. 2030 Stringtown Rd, Suite 200 Grove City, OH 43123
   Fax: (614) 544-0064 Phone: (614) 544-0054