OhioHealth

PATIENT REFERRAL FORM

OhioHealth Physician Group
Colon & Rectal 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** ☐ **Colonoscopy** ☐ **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**

☐ Bruce Kerner MD ☐ William Main DO

Fax: (614) 533-1213 Phone: (614) 864-1000

4882 East Main Street Suite 220 Columbus, OH 43213

☐ Scott Brill MD ☐ Melinda Jack MD

☐ William Wise Jr MD

Fax: (614) 533-0589 Phone: (614) 566-4449

500 Thomas Lane Suite 4A Columbus, OH 43214

What tests have been done:

☐ X-RAY Date: _____ ☐ CT Date: _____ ☐ EGD Date: _____ ☐ CT Date: _____

☐ MRI Date: _____ ☐ EUS Date: _____ ☐ LABS Date: _____ ☐ _____ Date: _____

☐ U/S Date: _____ ☐ PET Date: _____

****Consultations for Cancer, Crohn's disease, Diverticulitis, Polyps, Mass or Ulcerative Colitis require the patient medical records at time of visit****

APPOINTMENT INFORMATION: ***Return to referring physician***

Date Scheduled: _____ Time _____

Physician _____ Location _____

Appointment Info back to referring physician ☐ Faxed ☐ New patient packet mailed **Date**: _____ 3/1/21