

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 # _____ <p style="text-align: center;"><u>Listing of physicians, locations and FAX numbers</u></p> <p style="text-align: center;"><u>on back of form</u></p>	<p><u>What tests have been done:</u></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Test</th> <th style="text-align: left; border-bottom: 1px solid black;">Facility</th> <th style="text-align: left; border-bottom: 1px solid black;">Date</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> X-RAY _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> CT _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> MRI _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> EMG _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> OTHER TESTING _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Test	Facility	Date	<input type="checkbox"/> X-RAY _____	_____	_____	<input type="checkbox"/> CT _____	_____	_____	<input type="checkbox"/> MRI _____	_____	_____	<input type="checkbox"/> EMG _____	_____	_____	<input type="checkbox"/> OTHER TESTING _____	_____	_____
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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:** _____ 9/18/2020

Physicians
Locations

<u>Sports & Family Medicine</u>		<u>Circle location</u>	
<input type="checkbox"/> Benjamin Ahrens DO		6	1. 3705 Olentangy River Road, Suite 260 Columbus, OH 43214 Fax: (614) 533-6609 Phone: (614) 533-6600
<input type="checkbox"/> Monique Brady MD		2	2. 1010 Refugee Road, Suite 200 Pickerington, OH 43147 Fax: (614) 788-4222 Phone: (614) 788-4232
<input type="checkbox"/> Darrin Bright MD		8	3. 300 Polaris Parkway, Suite 2150 Westerville, OH 43082 Fax: (614) 533-3289 Phone: (614) 533-3280
<input type="checkbox"/> Ken Cayce MD		4	4. 801 OhioHealth Blvd, Suite 200 Delaware, OH 43015 Fax: (740) 615-0279 Phone: (740) 615-0270
<input type="checkbox"/> Natalie Dick DO		4	5. 6955 Hospital Drive Dublin, OH 43016 Fax: (614) 566-1429 Phone: (614) 566-1420
<input type="checkbox"/> Jason Diehl MD		5	6. 4343 All Seasons Drive, Suite 100 Hilliard, OH 43026 Fax: (614) 544-1156 Phone: (614) 544-1155
<input type="checkbox"/> Kristen Dimitris MD		3	7. 303 E. Town St, 2 nd Floor Columbus OH 43215 Fax: (614) 533-6609 Phone: (614) 533-6600
<input type="checkbox"/> Douglas DiOrio MD		1	8. 5868 N. Hamilton Rd, 2 nd Flr Columbus, OH 43230 Fax: (614) 788-9406 Phone: (614) 533-6600
<input type="checkbox"/> Anthony Ewald MD		3	9. 2030 Stringtown Rd, Suite 200 Grove City, OH 43123 Fax: (614) 544-0064 Phone: (614) 544-0054
<input type="checkbox"/> Craig Fortman DO		7 9	
<input type="checkbox"/> John Hedge DO		1	
<input type="checkbox"/> Thomas Hospel MD		5	
<input type="checkbox"/> Kristin Lafferty DO		9	
<input type="checkbox"/> Donald LeMay DO		2	
<input type="checkbox"/> Austen Musick DO		6	
<input type="checkbox"/> Robert Sickles MD		5	
<input type="checkbox"/> Ryan Siegel DO		2	
<input type="checkbox"/> Vismai Sinha MD		1	
<input type="checkbox"/> Marguerite Weston MD		3	