OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Endocrinology

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: _____

☐ Primary Care ☐ Specialty Office Phone #: _____ Fax#: _____ Form completed by: _____

Reason for Referral: _____

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** ☐ **First Available Provider** ☐ **Routine**

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REASON for visit and documentation REQUIRED WITH EACH REFERRAL AND DIAGNOSIS:

This practice does not treat patients with the following diagnosis: Transgender patients requiring hormone replacement therapy.

☐ **Diabetes** (Gestational Diabetes – Athens and Mansfield locations only)
Progress Notes, All Diabetic labs w/i last year, medication list

☐ **Thyroid**
Progress Notes, All Thyroid labs w/i last 6 months (MUST include TSH, T4, T3, etc), any imaging w/i last 12 months, medication list

☐ **Osteoporosis**
Progress Notes, Labs (MUST include Vitamin D & Calcium), imaging and report(s) w/i last 24 months, medication list

☐ **Pituitary**
Progress Notes, MRI w/I last 12 months (if available), medication list; labs (if available)

☐ **Adrenal**
Progress Notes, Adrenal Labs (MUST include Potassium & Cortisol), any imaging w/i last 12 months, medication list; labs (if available)

APPOINTMENT INFORMATION: Date Scheduled: _____ Time _____ Physician _____

Location _____ Appt Info back to referring physician ☐ Faxed ☐ New patient packet mailed Date: _____ 10/23/2026