OhioHealth

PATIENT REFERRAL FORM

OhioHealth Physician Group
Nonsurgical Orthopedics

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** ☐ **Office to call patient** ☐ **Patient to call office**

☐ Benjamin Burkam MD ☐ Jason Dapore DO
☐ Joseph Ruane DO

FAX: (614) 566-3895 Phone: (614) 566-3810

3773 Olentangy River Rd Columbus OH 43214
323 E. Town St Columbus OH 43215

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**: ______________ 06/01/21