OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Nephrology

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 (if applicable) _____

Is this referral URGENT? ☐ **YES** ☐ **NO**

☐ First Available

☐ Sunil Akkina MD ☐ Mohan Kamadana MD
☐ Swapna Kamadana MD ☐ Jackson Liu MD
☐ Ravindra Pawar MD

Fax: (419) 774-0571 Phone: (419) 774-0478

1100 Redwood Dr Ashland 44805
1820 E. Mansfield St Bucyrus 44820
921 E Franklin St Kenton 43326
661 S Trimble Road Mansfield 44906
1035 Harding Memorial Pkwy Marion 43302
651 W. Marion Rd. Mt Gilead 43338
14 Woodlake Trail Mt Vernon 43050
290 Benedict Ave Norwalk 44857
209 Rae Ct Willard 44890

***REQUIRED WITH REFERRAL*:**

☐ Imaging (MRI, CT, US)
☐ History & Physical
☐ Labs (demonstrating kidney function for past 12 months)
☐ Current Medication List
☐ Other _____

APPOINTMENT INFORMATION: ***Return to referring physician*** Date Scheduled: _____ Time _____

Physician _____ Location _____

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