OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Gynecology

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

Patient Needs an Appointment: ☐ **ASAP** ☐ **Within one week** ☐ **Patient's Convenience** ☐ **Office to call patient** ☐ **Patient to call office**

☐ Anita Somani MD
☐ Shivkamini 'Mini' Somasundaram MD
☐ Brienne Williford MD
☐ Jennifer Cartmel CNP
☐ Erica Fog CNP
☐ Aashka Patel CNM
☐ Susan Saunders CNP

3600 Olentangy River Rd, Suite A Columbus OH 43214
Fax: (614) 583-5559 Phone: (614) 583-5552

What tests have been done:

☐ Gyn U/S ☐ CT
☐ MRI ☐ X-Ray
☐ Labs
☐ Colposcopy ☐ LEEP
☐ Hx Abnormal Pap Smear
☐ Other Testing: ______________________
☐ Other Testing: ______________________
☐ Other Testing: ______________________

****Please include patient's current medication list****

If outside of OhioHealth, please fax all pertinent medical records PRIOR to appointment for review. 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: ____________ 10/28/2020