



PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Urogynecology

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 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

Form with appointment options (First Available, Nicole Book MD, etc.) and a table for 'What tests have been done:' with columns for Test, Facility, and Date.

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: