OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Infectious Diseases

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** ☐ **Patient's Convenience** ☐ **Office to call patient** ☐ **Patient to call office**

☐ Ian Baird MD
☐ Jessica Barrett DO
☐ Megan Buller MD
☐ George Gianakopoulos MD
☐ Wissam Sabbaugh MD
☐ Edwin Vargas MD
☐ Gina Zilioli MD
☐ Morgan Osam-Duodo PA-C
☐ Jason Tagliarina CNP

FAX: (614) 788-5210 Phone: (614) 788-5200
3555 Olentangy River Road, Suite 3080
Columbus, OH 43214

☐ Prity Vaidya, MD

FAX: (419) 526-8854 Phone: (419) 526-8044
295 Glessner Ave Mansfield OH 44903

PLEASE FAX THE FOLLOWING WITH REFERRAL FORM

__ Recent Progress Notes
__ Recent Labs
__ Current Medication List
__ Other pertinent medical records

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