OhioHealth

PATIENT REFERRAL FORM

OhioHealth Physician Group
Robotic Urologic and Cancer Surgery

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**

☐ Ryan Hedgepeth MD

Fax: (614) 533-0128 Phone: (614) 544-8104

7450 Hospital Dr. - Suite 300 Dublin, Ohio 43016

What tests have been done:

	Test	Facility	Date
☐ Pathology:	_____	_____	_____
☐ Imaging:	_____	_____	_____
☐ Labs:	_____	_____	_____
☐ Other:	_____	_____	_____
☐ Other:	_____	_____	_____

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**: _____ 3/1/21