Patient Referral Form

OhioHealth Physician Group – Rapid Cancer Diagnostic Clinic

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:* _____

☐ Suspected type of cancer: _____ ☐ Other: _____

Insurance information: **SEND COPY OF INSURANCE CARD (FRONT AND BACK) - AND ANY RELATED PATIENT RECORDS / REPORTS**

Referral / Authorization / Claim number _____ Insurance company: _____ ☐ Self pay

☐ BWC Employer: _____ Date of injury: _____

MCO Name: _____

Rapid Cancer Diagnostic Clinic
OhioHealth Bing Cancer Center
500 Thomas Lane, Suite A1
Columbus, Ohio 43214

Fax: (614) 566-6900

Phone: (614) 566-4300

What tests have been done:

☐ X-RAY	Date: _____	☐ _____	Date: _____
☐ MRI	Date: _____	☐ _____	Date: _____
☐ U/S	Date: _____	☐ Other:	_____
☐ CT	Date: _____		_____
☐ LABS	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: _____

Appointment info back to referring physician ☐ Faxed ☐ New patient packet mailed Date: _____

OhioHealth