OhioHealth

PATIENT REFERRAL FORM

OhioHealth Physician Group
Pain Management

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**

☐ Shruti Kapoor MD
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☐ Aleksey Prok MD
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1050 Delaware Ave Marion OH 43302

What tests have been done:

☐ X-RAY Date: _____ ☐ CT Date: _____

☐ MRI Date: _____ ☐ EMG Date: _____

☐ _____ Date: _____ ☐ _____ Date: _____

Is the patient on long-term opiate therapy? ☐ Yes ☐ No

The patient has:

☐ exhibited drug seeking behavior

☐ been non-compliant with opioid therapy in the past

☐ demonstrated accelerated medication use or misplaced controlled medications

☐ been discharged from another pain practice

☐ raised concerns about opioid misuse, abuse or addiction

☐ none

Physician Signature _____ Date _____

*Physicians do not write prescriptions for controlled substances on initial visit

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**: _____ 10/16/19