PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Behavioral Health

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**

☐ Upender Gehlot MD ☐ Patricia Newton MD

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☐ Shyamala Bheemisetty MD

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☐ Transition and Consultation Services

☐ Group Programming

FAX: (614) 566-6846 Phone: (614) 566-4414
3820 Olentangy River Road Columbus OH 43214

FAX: (614) 544-1359 Phone: (614) 544-1061
5141 W. Broad Street, Suite 115 Columbus OH 43228

Current Symptoms (i.e.: mood, affect, sleep, appetite):

Past Psych Treatment (inpatient, outpatient and reasons):

Current Psych Meds:

Past Psych Meds & Reason Discontinued:

APPOINTMENT INFORMATION: ***Return to referring physician*** Date Scheduled: ______________ Time ______________

Physician ______________________ Location ______________________

Appointment Info back to referring physician ☐ Faxed ☐ New patient packet mailed **Date**: ______________