OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Gynecologic Oncology

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**

Physician Consulted ☐ **First Available**

☐ Aine Clements MD ☐ Kellie Rath MD
☐ Stuart Pierce MD

Fax: (614) 566-1165 Phone: (614) 566-1150

1. 500 Thomas Lane – Suite 4B Columbus OH 43214
2. 6700 Perimeter Drive, Suite 210 Dublin OH 43016

What tests have been done:

Test	Facility	Date
☐ _____	_____	_____
☐ _____	_____	_____
☐ _____	_____	_____

☐ OTHER TESTING _____

REFERRING PHYSICIAN to mail all pathology slides to our office if not done at Ohio Health.

APPOINTMENT INFORMATION: ***Return to referring physician***

Date Scheduled: _____ Time _____

Physician _____ Location _____

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

6/7/2021