

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

Circle Location	<u>Locations</u>
<input type="checkbox"/> First Available	
<input type="checkbox"/> Kevin Banks, MD 1 Urological Surgery/Minimally Invasive Surgery	1) 500 Thomas Lane Suite 3-G Columbus, OH 43214 Fax Referral Form to: (614) 533-0177 Phone: (614) 788-2870
<input type="checkbox"/> Ryan Hedgepeth, MD, MS 1 2 Urological Oncology/Laparoscopic & Robotics	2) 5141 W. Broad St. Suite 180 Columbus, OH 43228 Fax Referral Form to: (614) 544-1853 Phone: (614) 544-1460
<input type="checkbox"/> Gregory Lowe, MD 1 Men's Sexual Health/Male Infertility/Erectile Dysfunction	3) 300 Polaris Parkway Suite 2300, Westerville, OH 43082 Fax Referral Form to: (614) 533-0177 Phone: (614) 788-2870
<input type="checkbox"/> Ketul Shah, MD 3 4 Female Urology/Male Pelvic Reconstructive	4) 1040 Delaware Ave, Marion, OH 43302 Fax Referral Form to: (614) 533-0177 Phone: (614) 788-2870
<input type="checkbox"/> Abhishek Patel, MD 2 Urological Surgery/Male Infertility	
<input type="checkbox"/> Andrew Smock, MD 2 General Urology	
<input type="checkbox"/> Alex Falk, PA 1 2	
<input type="checkbox"/> Wynne Barnhart, PA 1	

APPOINTMENT INFORMATION: Return to referring physician

Date Scheduled: _____ Time _____

Physician _____ Location _____

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