OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Urology Physicians

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
☐ **First Available**	
☐ **Kevin Banks, MD** Urological Surgery/Minimally Invasive Surgery	1
☐ **Ryan Hedgepeth, MD, MS** Urological Oncology/Laparoscopic & Robotics	1 2
☐ **Gregory Lowe, MD** Men's Sexual Health/Male Infertility/Erectile Dysfunction	1
☐ **Ketul Shah, MD** Female Urology/Male Pelvic Reconstructive	3 4
☐ **Abhishek Patel, MD** Urological Surgery/Male Infertility	2
☐ **Andrew Smock, MD** General Urology	2
☐ **Alex Falk, PA**	1 2
☐ **Wynne Barnhart, PA**	1

Locations

1) 500 Thomas Lane Suite 3-G Columbus, OH 43214
Fax Referral Form to: (614) 533-0177
Phone: (614) 788-2870

2) 5141 W. Broad St. Suite 180 Columbus, OH 43228
Fax Referral Form to: (614) 544-1853
Phone: (614) 544-1460

3) 300 Polaris Parkway Suite 2300, Westerville, OH 43082
Fax Referral Form to: (614) 533-0177
Phone: (614) 788-2870

4) 1040 Delaware Ave, Marion, OH 43302
Fax Referral Form to: (614) 533-0177
Phone: (614) 788-2870

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

Date Scheduled: _____ Time _____

Physician _____ Location _____

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

4/12/17