OhioHealth

PATIENT REFERRAL FORM

OhioHealth Breast & Cancer Surgeons

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**

Physician Consulted	**Circle location preference**
☐ Mark Cripe DO	1 2
☐ Christine Habib MD	1 3 5
☐ Deepa Halaharvi DO	1 2 4

Fax Referral Form to: (614) 533-0438
Phone: (614) 566-0774

1. 285 E State Street Suite 300 Columbus, OH 43215
2. 5141 W. Broad Street Suite 115 Columbus, OH 43228
3. 4882 E. Main Street Suite 110 Columbus, OH 43213
4. 1010 Refugee Road Suite 310 Pickerington, OH 43147
5. 300 Polaris Parkway Suite 1050 Westerville, OH 43082

Mark Area of Concern

☐ Abnormal Imaging	☐right	☐left	☐both
☐ Breast lump	☐right	☐left	☐both
☐ Breast Pain	☐right	☐left	☐both
☐ Nipple Discharge	☐right	☐left	☐both
☐ Cancer	☐right	☐left	☐both

☐ High Risk

******Fax copy of Insurance Card (front & back), related dictations and reports along with referral form******

Patients to hand carry any films and reports to their appointment if not done at OhioHealth. 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**: _____

2/10/17