OhioHealth
BELIEVE IN WE™

# *PATIENT SCHEDULING/REFERRAL FORM*

**OhioHealth Gastroenterology 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 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** | **Circle location Preference** |
|---|---|
| ☐ Sumit Kapoor MD MPH (Gastro & Hepatology) | 1 |
| ☐ Seth Levin DO (Gastro & Hepatology) | 1 2 |

**Fax: (614)544-1890**
**Phone: (614) 544-1891**

1. 5131 Beacon Hill – Suite 200 Columbus, OH 43228
2. 6905 Hospital Drive – Suite 200 Dublin, OH 43016

***PROCEDURE REQUESTED:***

☐ Colonoscopy ☐ EGD ☐ ERCP ☐ EUS

**MEDICAL HISTORY:** **Does patient currently have or have a history of:**

☐ **Diabetes** ☐ **Kidney Disease/Failure** ☐ **Heart Disease**

**Allergies** _____

**Ht:** _____ **Wt:** _____ **Sleep Apnea Y / N C-Pap Machine used Y / N**

***REQUIRED WITH REFERRAL*: recent x-rays, labs, progress note, H/P and medication sheet**

**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**: _____