OhioHealth

Patient Scheduling/Referral Form

OhioHealth Gastroenterology Physicians

Patient information

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, Ohio 43228
2. 6905 Hospital Drive, Suite 200 Dublin, Ohio 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: ☐ Yes ☐ No C-Pap Machine used: ☐ Yes ☐ No

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**: _____

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