OhioHealth

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

☐ Sumit Kapoor MD (Gastro & Hepatology)

☐ Seth Levin DO (Gastro & Hepatology)

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

5131 Beacon Hill – Suite 200
Columbus, OH 43228

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**

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

Date Scheduled: _____ Time _____

Physician _____ Location _____

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

11/28/17