PATIENT REFERRAL REQUEST FORM

Matthew Bernhard, MD, Stephen Yoder, MD

45 Amberwood Parkway, Ashland, OH 44805 2180 Stumbo Rd., Ontario, OH 44906

Thank you for choosing OhioHealth Orthopedic & Sports Medicine Physicians. We look forward to partnering with you in your patient's care.

Date: ____________

Patient Information:

Patient Name: ______________________________

Address: ______________________________

City: ______________________ State: __________ Zip: __________________

Home Phone: ______________________ Cell Phone: ______________________

Social Security Number: ______________________ DOB: ______________________

Language: ______________________ Interpreter Need? Y / N

Special needs: ______________________________

Referring Provider Information:

Referred by: ______________________ Phone: __________________ Fax: ________________

Referral Information:

Reason for Referral: ______________________________

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How long has he/she had problem: ______________________ **Due to injury: Y / N**

Has he/she seen another physician for this condition? Y / N If yes, who: ______________________

Has he/she had prior surgery? If so, where and when: ______________________

Diagnosis Code: ______________________ **If BWC – Allowed Diagnosis Code:** ______________________

Prior Testing:	**Facility**	**Date**
X-Ray	______________________	__________________
CT	______________________	__________________
MRI	______________________	__________________
EMG	______________________	__________________
Other Testing	______________________	__________________
Therapy	______________________	__________________

Please fax all office notes, radiology reports, MRI reports, and medication list to (419) 289-1154 (Ashland) or (419) 709-8991 (Ontario). If you have any questions, call (419) 289-1774 (Ashland) or (419) 709-8989 (Ontario).

(OhioHealth MOI use only)

Patient scheduled: Date/Time ____________ /__________AM/PM with Dr. ______________________

Patient NOT scheduled Reason: ______________________________

Thank you for your referral. However, we have been unsuccessful in scheduling this patient. Feel free to call our office with any questions.

Completed by: ______________________ Date faxed to referring physician: ______________