PATIENT REFERRAL REQUEST FORM

Mark Leeson, MD, 24 Morris Rd, Suite 2, Shelby, OH 44875
Phone: (419) 347-4177 FAX: (419) 347-9079

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: _____

_____

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) 347-9079.
If you have any questions, please call (419) 347-4177.

(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: _____