

PATIENT REFERRAL REQUEST FORM

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Phone: (419) 756-8899 FAX: (419) 520-3561

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 419-520-3559.

If you have any questions, please call 419-756-8899.

(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: _____