



Ohio Gastroenterology Group, Inc.

Referral Form- Fax to (614)754-5601

Referring Physician: _____ Date: _____ Completed By: _____

Referring Office Phone #: _____ Fax #: _____

Patient Name: _____ SS#: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Mobile Phone #: _____

Insurance: _____ Does insurance require a referral? Yes / No (If yes, please attach a copy of referral)

Please send the following information with your completed referral:

- Copy of the patient's insurance card (front and back)
- Any relevant medical records

Referral For:

- Office Consultation
- Colonoscopy
- Upper Endoscopy (EGD)
- Other: _____

Patient Scheduling:

- Emergency – **PLEASE FAX FORM & CALL OUR OFFICE TO SCHEDULE**
- Urgent (Within 1 to 2 weeks)
- Next Available

Reason For Referral (Diagnosis or Symptoms): _____

Referred To:

- Any Location / Any Physician

Specific Location:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> North
3800 / 3820 Olentangy River Road
Columbus, OH 43214 | <input type="checkbox"/> East
85 McNaughten Road, Suite 320
Columbus, OH 43213 | <input type="checkbox"/> West / Downtown
777 W. State Street, Suite 400/402
Columbus, OH 43222 | <input type="checkbox"/> Dublin
6670 Perimeter Dr, Suite 200
Dublin, OH 43016 |
|--|--|--|---|

Specific Physician:

- _____

Please fax all completed referral forms to (614) 754-5601.

For questions or to reach our central scheduling department directly, please call (614) 754-5600.

OHIO GASTROENTEROLOGY GROUP, INC. USE ONLY:

Contact Log

Patient Scheduled

Date / Time of Scheduled Visit: _____ / _____ Physician Name: _____ Location: _____

Thank you for your referral! We appreciate the opportunity to participate in your patient's care.

Patient Not Scheduled

Reason: _____

Thank you for your referral! However, we have been unsuccessful in scheduling this patient. Please contact the patient for the appropriate follow-up. Feel free to call our office with any questions.

Completed By: _____

Date Faxed To Referring Physician: _____

CONFIDENTIALITY NOTICE

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