OhioGastro
Ohio Gastroenterology Group, Inc.

OhioEndo
Ohio Gastroenterology Group, Inc.

Referral Form- Fax to (614)754-5601

Referring Physician: ______________________________ Date: ____________________ Completed By: _______________

Referring Office Phone #: __________________________ Fax #: ____________________ Direct Address: ___________________

Patient Name: ____ SS#: ______________________DOB: __________ Sex: M or F

Address: ___________________________________City: ________________State: _______ Zip: ________

Patient's email address: ____

Home Phone #: ______________________ Work Phone #: _____________________ Mobile Phone #: ____________________

❒ Patient agrees to accepts text messages to the provided mobile phone number regarding information on scheduling their appointment

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

Subscriber ID Number: __________________________Subscriber Name & DOB:____________________ (if different than the patient)

Please send the following information with your completed referral:

- ❒ Copy of the patient's insurance card (front and back) – card must be legible
- ❒ **Any relevant medical records** ❒ Weight____________ ❒ Height____________
- ❒ Patient has had endoscopic procedures within the last 5 years

Referral For:

- ❒ Office Consultation
- ❒ Colonoscopy
- ❒ Upper Endoscopy (EGD)
- ❒ Endoscopic Ultrasound (EUS)
- ❒ Other: _______________________

Reason For Referral (Diagnosis or Symptoms): ____

Referred To:

- ❒ Any Location / Any Physician

Specific Location:

- ❒ NORTH - 3400 Olentangy River Rd., Cols. OH 43202
- ❒ EAST – 85 McNaughten Rd., Ste. 320, Cols. OH 43213
- ❒ PICKERINGTON- 1025 Refugee Rd., Pickerington OH 43147
- ❒ DUBLIN – 6670 Perimeter Dr,. Ste. 200, Dublin, OH 43016
- ❒ WESTERVILLE – 430 Altair Parkway Ste. 110, Westerville, OH 43082

Specific Physician:

❒ _________________________

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

To access our online referral, please visit www.ohiogastro.com & click on "PHYSICIAN REFERRALS".

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

If your patient's needs are emergent, please have the patient's physician call our office at 614-754-5500.

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