



**Referral Form – Fax to (614) 486-9665 or e-mail to referral@columbusarthritis.com**

Referring Physician: \_\_\_\_\_ Date: \_\_\_\_\_ Completed By: \_\_\_\_\_

Referring Office Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Mobile #: \_\_\_\_\_

Insurance: \_\_\_\_\_ Does insurance requires 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:**

**Patient Scheduling:**

- |   |   |
|---|---|
| <input type="checkbox"/> Office Consultation      | <input type="checkbox"/> Emergency – <b>PLEASE FAX FORM &amp; CALL OUR OFFICE TO SCHEDULE</b> |
| <input type="checkbox"/> Infusion (include order) | <input type="checkbox"/> Urgent (Within 1 to 2 weeks)   |
| <input type="checkbox"/> Other: _____             | <input type="checkbox"/> Next Available   |

**Reason For Referral (Diagnosis or Symptoms):** \_\_\_\_\_

**Referred to:**

**Specific Physician:**

- |  |                                |
|--|--------------------------------|
| <input type="checkbox"/> Any Physician | <input type="checkbox"/> _____ |
|--|--------------------------------|

**Please fax all completed referral forms to (614) 486-9665 or e-mail to referral@columbusarthritis.com. For questions or to reach our central scheduling department directly, please call (614) 486-5200**

**COLUMBUS ARTHRITIS CENTER, INC. USE ONLY:**

Contact Log:

\_\_\_\_\_

- Patient Scheduled**  
Date/Time of Scheduled Visit: \_\_\_\_\_/\_\_\_\_\_ Physician Name: \_\_\_\_\_  
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**

**The information contained in this facsimile is intended only for the use of the individual or entity named above. This information may be privileged or confidential. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents is strictly prohibited by law. If you have received this transmission in error please call the sender at the above number to arrange for destruction or return of transmission at our expense.**