



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:

- Office Consultation
- Infusion (include order)
- Other: _____
- 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:

Specific Physician:

- Any Physician
- _____

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

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