

Consultation Request Form – Fax form to 614-764-1707

| Patient Name: | Patient Address: | |
|--|---|-------|
| Patient Home Phone #: | Patient Home Phone #: Cell Phone #: Patient SS# Primary Insurance: Secondary Insurance: Secondary Insurance: Secondary Insurance: Secondary Insurance: Secondary Insurance: Practice And Secondary Insurance: Secondary Insurance: Practice Name Secondary Insurance: Secondary Insurance: Secondary Insurance: | |
| Primary Insurance: | Primary Insurance: | |
| Referring Physician Information: Physician Name: Practice Name: City: State: Zip: Office Phone #: Office Fax #: Form completed by: Specific Reason for Referral: No: ** If a patient no shows their initial consultation, they will not be allowed to reschedule with our office ** REASON for visit and supporting documentation REQUIRED WITH EACH REFERRAL AND DIAGNOSIS: Diabetes: Progress Notes, All diabetes related labs from Diabetes: Progress Notes, All diabetes related labs from Phone: 614, 764, 0707 Fax: 644, 7707 | SEND COPY OF INSURANCE CARD (FRONT AND BACK) Referring Physician Information: Physician Name: | |
| Referring Physician Information: Physician Name: Practice Name: Practice Address: City: State: Zip: Office Phone #: Office Fax #: Form completed by: Specific Reason for Referral: No: ** If a patient pregnant? Yes: EDD: No: ** If a patient no shows their initial consultation, they will not be allowed to reschedule with our office ** REASON for visit and supporting documentation REQUIRED WITH EACH REFERRAL AND DIAGNOSIS: Diabetes: Progress Notes, All diabetes related labs from Diabetes: Progress Notes, All diabetes related labs from Physician Information: Zip: Zip: | Referring Physician Information: Physician Name: Practice Name: Practice Address: City: State: Zip: | |
| Practice Name: Practice Name: City: State: Zip: Office Phone #: Office Fax #: Form completed by: Specific Reason for Referral: | Physician Name: Practice Name: Practice Address: City: State: Zip: | |
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| Is the patient pregnant? Yes: ** If a patient no shows their initial consultation, they will not be allowed to reschedule with our office ** ** If a patient no shows their initial consultation, they will not be allowed to reschedule with our office ** ** If a patient no shows their initial consultation, they will not be allowed to reschedule with our office ** ** Place Information: Diabetes & Endocrinology Center of Ohio 7281 Sawmill Road, Dublin, Ohio 43016 Phone: 614.764.0707 Fax: 614.764.1707 | | |
| Is the patient pregnant? Yes: ** If a patient no shows their initial consultation, they will not be allowed to reschedule with our office ** ** If a patient no shows their initial consultation, they will not be allowed to reschedule with our office ** ** If a patient no shows their initial consultation, they will not be allowed to reschedule with our office ** ** Place Information: Diabetes & Endocrinology Center of Ohio 7281 Sawmill Road, Dublin, Ohio 43016 Phone: 614.764.0707 Fax: 614.764.1707 | Specific Reason for Referral: | |
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| the last 6 months, medication list ☐ Thyroid Disorders: Progress Notes, thyroid labs from the last 6 months, any prior thyroid ultrasound/nuclear scans, prior thyroid FNA results, medication list ☐ Osteoporosis/Hypercalcemia/Hyperparathyroidism: Progress Notes, most recent DXA Scan, any available bone labs (PTH, CMP, vitamin D), medication list ☐ Pituitary: Progress Notes, Pituitary MRI/Brain CT, Pituitary labs, medication list | REQUIRED WITH EACH REFERRAL AND DIAGNOSIS: Diabetes & Endocrinology Center 7281 Sawmill Road, Dublin, Ohio 43 Phone: 614-764-0707 Fax: 614-764 | 43016 |