



## Access HealthColumbus Specialty Referral Form

Today's Date \_\_\_\_\_

Name of Patient \_\_\_\_\_  
(Last) (First) (Initial)

Parent/Guardian \_\_\_\_\_  
(Last) (First) (Initial)

Street Address \_\_\_\_\_ Telephone (home) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone (work) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Referred from \_\_\_\_\_  
(Private Practice, Clinic, Hospital)

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**Refer to: (Please choose one)**

- |  |  |
|--|--|
| <input type="checkbox"/> Allergy             | <input type="checkbox"/> Orthopedic              |
| <input type="checkbox"/> Cardiology          | <input type="checkbox"/> Otolaryngology          |
| <input type="checkbox"/> Dermatology         | <input type="checkbox"/> Pulmonary               |
| <input type="checkbox"/> Endocrinology       | <input type="checkbox"/> Physical Medicine       |
| <input type="checkbox"/> Gastroenterology    | <input type="checkbox"/> Physical Therapy        |
| <input type="checkbox"/> GYN                 | <input type="checkbox"/> Podiatry                |
| <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Rheumatology            |
| <input type="checkbox"/> Infectious Disease  | <input type="checkbox"/> Surgery-Cardio-Thoracic |
| <input type="checkbox"/> Nephrology          | <input type="checkbox"/> Surgery-General         |
| <input type="checkbox"/> Neurology           | <input type="checkbox"/> Surgery-Colon/Rectal    |
| <input type="checkbox"/> Neurosurgery        | <input type="checkbox"/> Surgery-Vascular        |
| <input type="checkbox"/> Ophthalmology       | <input type="checkbox"/> Urology                 |
| <input type="checkbox"/> Optometry           |  |

**Reason for Referral:**

\_\_\_\_\_  
\_\_\_\_\_

If you are ordering diagnostics, please include diagnostic code \_\_\_\_\_

\_\_\_\_\_  
**Doctor Name (print or stamp)** **Date**

\_\_\_\_\_  
**Staff Scheduling Referral (please print)** **Phone Number**

*Please fax to Access HealthColumbus at 614-884-0123.*