OSU Physicians
Division of Endocrinology, Diabetes & Metabolism
543 Taylor Ave, 2nd Floor
Columbus, OH 43203
Phone: 614-685-3333
Fax: 614-366-0345

Request for New Patient Consultation

Please Fax to 614-366-0345

Please include:

- ☐ **1 year of Relevant Medical Records (See attached list) & Office Visit Notes**
- ☐ **Current Medication List**
- ☐ **Diabetes- Recent Glucose Logs**
- ☐ **Copy of insurance card**

***** If the patient has no insurance please call Financial Assistance at 800-834-1564 *****

Date:_____

Referring physician:_____ NPI:_____

Address:_____

_____

Phone #_____ Fax #_____

Patient Information:

ICD-10 Code(s) REQUIRED for referral _____

Name:_____ DOB:_____ SS#:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Special scheduling instructions: _____

- ☐ **Patient Needs Interpreter - Language _____**

Ins. Carrier:_____

_ Phone #:_____

ID#:_____ Group #:_____

Does Insurance require a referral No ___ Yes ____ (If yes, please attach a copy of the referral)

Referral for: Office consultation _____ Transfer of care _____

Requested Doctor (if available): _____