Nelsonville Referring PCP

Central Ohio Cardiovascular Physicians Referral Form

Drs. Gatto, Levin, Li, Susser

For Questions Call: 800-486-2002

Fax Medical Records To: 614-777-4509

www.cocvc.com

Referral Information

Referral Doctor: ____________________
Sent by: __________________________
Phone #: __________________________
Fax #: ____________________________

*If new referral DR please fill in **

*Address: __________________
*City: __________________
*State/Zip: __________________
*Medicaid #: __________________
*UPIN #: __________________
NPI # __________________

Patient Information

Patient name:____________________________
Address:________________________________
City:___________________________________
State/Zip:_______________________________
Phone(Work):____________________________
Phone (Home):___________________________
SS#:____________________________________
D.O.B:__________________________________
Primary Insurance: _______________________

Diagnosis:______________________

Please check the following:

☐ **Insurance card faxed****
**(we are verifying coverage before appt)

Primary Insurance: ____________________

Secondary Insurance: ____________________

☐ Patients instructed to bring all medications and supplements in orginal containers

☐ EKG and Labs faxed

Service or Procedure Ordered

__________ **Cardiovascular Consultation**

__________ **Preoperative Cardiac Assessment**

Other Tests

__________ ***24hr. Ambulatory BP Monitor**

**(ICD code 796.2 only)*

____
Referring Physician Signature

(This section to be completed by COCP)

Patient's appointment date: __________ time: _________ with Dr. ___________________

Location:
_______ 5131 Beacon Hill Rd., Ste 120 Columbus
_______ 6670 Perimeter Dr. Ste. 140 Dublin
_______ 171 Morey Dr., Ste C Marysville
_______ 1950 Mt. St. Marys Dr. Nelsonville (DHON)

Completed by: ______________________________ Date faxed/ emailed back: _______________

Thank you for your referral!

coc_Referral+form_NSVL.xls
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