350 W. Wilson Bridge Rd., Suite 200
Worthington, Ohio 43085

5060 Bradenton Ave., Suite B
Dublin, Ohio 43017

2030 Stringtown Rd, Suite 210
Grove City, OH 43123

Patient Referral Appointment Request

Please fax to:
Orthopedic Foot & Ankle Center
Fax: (614) 895-8810
E-mail: ofaappts@orthofootankle.com
Phone: (614) 895-8747

Patient Information:

Name: ____ DOB:____________________

Address: ____

Phone: _________________________________ Insurance: ______________________________

Symptoms: ____

____

Has the patient had* (check all that apply):

______ Weight bearing x-rays
______ MRI
______ CT
______ Bone scan

** The patient will need to bring any weight bearing x-rays, CT or MRI films, reports, or other test results.*

Which Physician are you requesting?

_____ First available

_____ Gregory C. Berlet, MD
_____ Terry M. Philbin, DO
_____ Christopher F. Hyer, DPM
_____ Patrick E. Bull, DO
_____ Mark A. Prissel, DPM
_____ Justin R. Hudson, DPM
_____ Lynette R. Mehl, DPM

Referring Office Information (In case there are any questions):

Referring physician: ____
(First and Last name)

Contact person:__________________________ Phone:_____________Fax:________________

Notes: ____

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