Central Ohio Behavioral Medicine

2000 W. Henderson Rd., Suite 325
Columbus, OH 43220
Ph. 614-538-8300

Please fax completed form to: 614-538-1656

CLINICIAN REFERRAL FORM

We are currently in-network providers for OSU Health Plan, OSU Student Health Plan, and Ohio Health. We are not taking any new referrals for Medicare or Medicaid.

A complete referral includes:	*Referred to:*
1. New Patient Referral Form	□ Christine Bowers, MD
2. Brief History/Reason for Referral	□ Julie Guthrie, MD
3. Copy of Insurance Card	□ Peter Zafirides, MD
4. Signed Release of Information	□ First available psychiatrist

Referral Date: ___________________________	Referring Clinician: ______________________
Patient Name: ___________________________	Address:_________________________________
Address: _________________________________	City/Zip: _________________________________
City/Zip: _________________________________	Phone: __________________________________
Home Phone: ____________________________	Fax: ____________________________________
Cell Phone: ______________________________	Brief History/Reason For Referral:
DOB: ____________ Age: ____ Gender: _____	____
SSN: ____________________________________	____
Diagnosis: ______________________________	____
Insurance Carrier: _______________________	____
Member #: _______________________________	____