Student Health Services
The Ohio State University
1875 Millikin Road
Columbus, OH 43210

Last	First	MI
ID#		
(Place patient label here)		

REFERRAL SCHEDULING FORM

A copy of your insurance card is required in order to schedule appointment.

Name _____

Phone _____ Email _____

Local address _____

Method of transportation: (mark all that apply) □Have car □Uber/Lyft □Rely on friend □Bus □Walk

Translation services needed? □No □Yes, Language: _____ Hearing impaired? □No □Yes

Insurance: □Student Health Insurance Plan (NOT WILCECARE) □Other Private Insurance (please provider details below)

Insurance Name _____ Subscribers Name _____

Please provide times during the **DAY** that you will be available for your appointment. We make our best efforts to stay within the parameters given but cannot guarantee that we can meet your specifications.

Mon_____ Tues_____ Wed_____ Thurs_____ Fri_____

Additional availability on weekends for **MRI/CT appointments only**: Sat_____ Sun_____

Please read and initial the statements below:

_____ I am aware of the importance and understand the risks to my overall health if I do not keep this appointment.
_____ I have had the chance to ask questions that were answered to my satisfaction pertaining to this referral.
_____ I authorize Student Life Student Health Services (SLSHS) to release my health information that may be pertinent to this referral to the above physician/clinic.
_____ I acknowledge that I understand being referred by SLSHS does not guarantee health insurance coverage or full payment for services rendered by the referred provider, and I may be responsible for all or part of the charges.

Patient Signature _____ Date _____

Our referral team will be in contact with you via My BuckMD Secure Message.