PATIENT REFERRAL APPOINTMENT REQUEST

Please Fax to: SPORTS MEDICINE GRANT & ORTHOPAEDIC ASSOCIATES
Fax: 614.461.9155 Phone: 614.461.8174 ext. 235

PATIENT INFORMATION

Name (First): _____ **(Middle):** _____ **(Last):** _____

Day Time Phone Number: _____ **Alternate Phone Number:** _____

Insurance: _____

Diagnosis/Symptoms/Reason: _____

Referring Physician: _____

PHYSICIAN REQUESTED

☐ **B.RODNEY COMISAR, M.D.**
SPORTS MEDICINE

☐ **RAYMOND J. TESNER, D.O.**
SPORTS MEDICINE

☐ **F. PAUL DEGENOVA, D.O.**
SPINE & NECK

☐ **R. EARL BARTLEY, M.D.**
JOINT REPLACEMENT

☐ **GARY M. MILLARD, D.O.**
HAND & UPPER EXTREMITY

☐ **ROBERT A. FADA, M.D.**
JOINT REPLACEMENT

☐ **ANCE M.MAYNARD ,D.O.**
JOINT REPLACEMENT

REQUESTED APPOINTMENT

Date:____ /____ /____ Time: _____ Location: _____

SMGOA will notify the patient and the referring physician office the details of the patient appointment.

MAIN LOCATIONS:

DOWNTOWN
323 E. Town Street
Columbus, OH 43215

PICKERINGTON
417 Hill Road North
Pickerington, OH 43147

WESTERVILLE
300 Polaris Parkway
Westerville, OH 43082