



PATIENT REFERRAL FORM

Ohio Ear, LLC

1901 Ohio Drive, Grove City, OH 43123
Phone 614-259-7541 | Fax 949-994-4561

Referring offices: Please fax the completed form to **949-994-4561** along with recent office notes, pertinent test results, and a copy of the patient's insurance card (front and back). Questions? Call **614-259-7541**.

DATE OF REFERRAL	REFERRAL PRIORITY ☐ Routine ☐ Urgent (please also call our office)	DATE RECORDS SENT
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1. PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SEX ☐ M ☐ F
STREET ADDRESS		CITY	STATE	ZIP CODE
PRIMARY PHONE	ALTERNATE PHONE	EMAIL ADDRESS		
PREFERRED CONTACT METHOD ☐ Phone ☐ Text ☐ Email	PREFERRED LANGUAGE _____ ☐ Interpreter	PARENT / GUARDIAN NAME (IF MINOR)		

2. INSURANCE INFORMATION *Please attach a copy of the insurance card(s), front and back*

PRIMARY INSURANCE PLAN	MEMBER / SUBSCRIBER ID	GROUP NUMBER	PLAN PHONE
POLICYHOLDER NAME (IF NOT PATIENT)	RELATIONSHIP TO PATIENT	POLICYHOLDER DOB	REFERRAL / AUTH # (IF REQ.)
SECONDARY INSURANCE PLAN	MEMBER / SUBSCRIBER ID	GROUP NUMBER	NO INSURANCE ☐ Self-Pay

3. REASON FOR REFERRAL *Check all that apply*

☐ Complex or Chronic Ear Conditions	☐ Cochlear Implant Evaluation
☐ Surgical Evaluation	☐ Persistent Dizziness or Balance Problems
☐ Hearing Loss	☐ Second Opinion
AFFECTED SIDE: ☐ Left ☐ Right ☐ Both ☐ N/A	☐ Other: _____

4. CLINICAL INFORMATION

DIAGNOSIS / ICD-10 CODE(S)	SYMPTOM ONSET / DURATION
CLINICAL SUMMARY, PERTINENT HISTORY & TREATMENT TO DATE	
RECORDS ATTACHED ☐ Office Notes ☐ Audiogram ☐ Imaging (CT/MRI) Report ☐ Medication List ☐ Insurance Card ☐ Other	

5. REFERRING PROVIDER

REFERRING PROVIDER NAME & CREDENTIALS	NPI	PRACTICE NAME	
PHONE	FAX	OFFICE CONTACT PERSON	CONTACT EMAIL
REFERRING PROVIDER SIGNATURE			DATE

OHIO EAR USE ONLY Date Rec'd _____ ☐ Ins. Verified ☐ Auth Obtained Appt Date/Time _____ Provider _____ Initials _____

CONFIDENTIALITY NOTICE: This transmission contains protected health information that is confidential and intended only for the named recipient. If you received it in error, please notify Ohio Ear at 614-259-7541 and destroy all copies.

Ohio Ear, LLC • Patient Referral Form • Rev. 09/2026