COBM
Central Ohio Behavioral Medicine

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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 #: _____	_____