



ORTHOPEDIC
FOOT & ANKLE CENTER

300 Polaris Parkway, Suite 2000
Westerville, Ohio 43082

5060 Bradenton Ave., Suite B
Dublin, Ohio 43017

2030 Stringtown Rd, Suite 210
Grove City, OH 43123

20 University Estate Blvd., Suite 100
Athens, OH 45701

Patient Referral Appointment Request

Please fax to:

Orthopedic Foot & Ankle Center
Fax: (614) 895-8810
E-mail: ofaappts@orthofootankle.com
Phone: (614) 895-8747

Patient Information:

Name: _____ DOB: _____

Address: _____

Phone: _____ Insurance: _____

Symptoms: _____

Has the patient had* (check all that apply):

- _____ Weight bearing x-rays
- _____ MRI
- _____ CT
- _____ Bone scan

** The patient will need to bring any weight bearing x-rays, CT or MRI films, reports, or other test results.*

Which Physician are you requesting?

- _____ First available
- _____ Gregory C. Berlet, MD
- _____ Terry M. Philbin, DO
- _____ Christopher F. Hyer, DPM
- _____ Patrick E. Bull, DO
- _____ David S. Buchan, DPM
- _____ Mark A. Prissel, DPM
- _____ Justin R. Hudson, DPM

Referring Office Information (In case there are any questions):

Referring physician: _____
(First and Last name)

Contact person: _____ Phone: _____ Fax: _____

Notes: _____
