American Arthritis and Osteoporosis Care Center

Referral to
SHEREEN HASHMI, MD

Please complete this form and return it via fax 614- 781-1751 to our office. We will contact the patient, schedule the appointment and fax the appointment day/ time back to you.

Patient name:_____ Sex: M or F

Date of Birth:_____ S.S. # _____

Address: _____

City: _____ ST: _____ Zip: _____

Primary Phone: (____) _____Secondary Phone:(____) _____

REQUEST FOR CONSULT

Referring Physician: _____NPI # _____

Phone: (____) _____ Fax: (____) _____

Patient's Insurance Carrier: _____/ Plan: _____

Secondary Insurance? Carrier: _____/ Plan: _____

Please include a clear, legible copy (front & back) of the patient's insurance card(s) in order to schedule. Medical records pertinent to this consult (ie: office notes/lab/X-ray or DEXA reports) should also be included with this request.

Reason for consultation request: _____

THANK YOU FOR YOUR REFERRAL! YOUR PATIENT HAS BEEN SCHEDULED FOR THIS DATE: _____ TIME: _____

439 East Wilson Bridge Rd.
Worthington, OH. 43085
Phone: (614) 781-1749 Fax: (614) 781-1751