



2026 GOSHEN HEALTH

Provider Guide

For the most current information visit

GoshenHealth.com/Quick-Guide



Goshen Health

12/12/2025

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Goshen Center for
Cancer Care

Cutting-edge. Comprehensive. Collaborative care.

When you refer a patient to the Goshen Center for Cancer Care, you can rest assured that they will be cared for by a multidisciplinary team that includes fellowship trained medical, surgical and radiation oncologists; oncology nurses; naturopathic doctors; mind-body counselors and dietitians. Together, the care team considers all aspects of the patient's life and disease to provide the best possible treatment.

Your Cancer Care Team

We have a dedicated team of oncologists and cancer care specialists committed to delivering the best possible care you'll find anywhere. From initial diagnosis to recovery and beyond – we're all in this together.

Clinic Hours

Clinic Hours: Monday – Friday, 8:30 a.m. – 4:30 p.m.

Infusion Hours: Monday – Friday, 7:30 a.m. – 4:30 p.m.

Medical Oncology



Bolanle Adepoju, MD, MPH
*Internal Medicine, Hematology
Oncology, Medical Oncology*



Joseph Spahr, MD
Hematology Oncology



Lawrence Schilder, MD
Medical Oncology



**Ingrid Bowser, MSN, ANP-BC,
AOCNP, ACHPN, dipACLM**
Medical Oncology



Jonathan Newhall, PA-C
Medical Oncology



**Kristan Rheinheimer, RN, MSN,
FNP, OCN**
Medical Oncology



**Jessica Vander-Molen, MSN,
RN, FNP-BC**
Medical Oncology

Surgical Oncology



Urs von Holzen, MD, MBA, FACS
*Surgical Oncology,
Thoracic Surgery*



Sammy Bostaji, MD
Interventional Pulmonology



**Gopal Menon, MBBS, MD,
MPH, MBA**
Surgical Oncology



**Laura L. Morris, MD, MBA,
FACS, dipABLM**
*Breast Surgical Oncology,
Surgical Oncology*



Mark Ranzinger, MD, FACS
General Surgery, Thyroid Surgery



Sharmila Roy Chowdhury, MD
Surgical Oncology



Pamela Stone, MD, FACOG, FACS
Gynecologic Oncology



Patrick Viscardi, MD
Plastic Surgery



**Grace Darnell, MSN, NP-C,
FNP-BC, OCN**
*Gynecologic Oncology,
Surgical Oncology*



**Sheila Fleming, MSN,
APRN-BC, CRNFA**
*Breast Surgical Oncology,
Women's Health*



Elise Sharkey, PA
Surgical Oncology



**Taylor Torres, BSN, RN,
DNP, FNP-BC**
Breast Health



**Heather Whitehead, MCN,
RN, FNP-BC**
Surgical Oncology

Radiation Oncology



Irina Sparks, MD
Radiation Oncology



Houman Vaghefi, MS, MD, PhD
Radiation Oncology



James Wheeler, MD, PhD
Radiation Oncology



Leon Coody, Jr, MSN, FNP-BC
Radiation Oncology

Integrative Care



LaToya Lewis, ND, FABNO, PMP
Naturopathic Oncology
Naturopathic Medicine



Emily Moore, ND, LAc, FABNO
Acupuncture, Naturopathic Oncology



Maria Brown, RD, CD
Oncology Nutrition



Maricel Lopez-Colon, RD, LDN
Oncology Nutrition



Kim Mathews, MS, LMHC, CT
Mind-Body Counselor



Bethany Swope, MS Ed, LMFT
Mind-Body Counselor



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RAPID REFERRAL FORM

To expedite the process, please reference Required Oncology Records Checklist to be included with referral.

If sending the C-CDA, this form does not need to be filled out. Please be sure to include reason for referral and indicate if records are available in Meditech.

Today's Date:

DEMOGRAPHICS PLEASE VERIFY BELOW INFORMATION IS INCLUDED IF ATTACHING DEMOGRAPHIC SHEET FROM YOUR FACILITY'S EMR

Name: _____ Birthdate: _____ M ____ F ____

Address: _____ City: _____ State: ____ Zip: _____

Preferred patient phone #: _____ E-mail: _____

Contact person if not patient: _____ Relationship: ____ Phone #: _____

Language preferred: _____ Interpreter needed: Y N Social Security# _____

INSURANCE

Insurance Co. _____ Policy # _____ Group # _____

REFERRAL

Reason for referral: _____ Second opinion? Y N

Diagnosis: _____ Date of diagnosis: _____ Has patient received treatment? Y N

Referring Physician: _____ Specialty: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone#: _____ Fax#: _____ Direct messaging email: _____

Provider choice: First available _____ Preferred Provider(s): _____

COMMUNICATION

You will receive faxed confirmation once the appointment is scheduled. Our office will directly contact your patient with scheduling information. Thank you for referring your patient to Goshen Center for Cancer Care.



Medical Oncology Required Records Checklist

Patient Name: _____

DOB: _____

ONCOLOGY GENERAL: PLEASE INCLUDE ALL RECORDS BELOW WITH REFERRAL

- Referring provider's most recent office note pertaining to diagnosis
- Imaging from past year – Including CT, PET, MRI, Ultrasound, Nuclear Medicine, MUGA/Echo
- Most recent pathology report as well as pathology report from initial diagnosis
- Labs from past year
- Chemotherapy and/or Radiation treatment summary

DISEASE SPECIFIC: PLEASE INCLUDE DISEASE SPECIFIC RESULTS IF AVAILABLE

- | | | |
|--|---|---|
| <input type="checkbox"/> ACUTE LEUKEMIA | Flow Cytometry All Bone Marrow Pathology | Cytogenetics |
| <input type="checkbox"/> BREAST CANCER | ER/PR DEXA scan Oncotype DX testing FISH/CISH if HER2 initial testing is indeterminate | HER2 BRCA testing Mammogram/US/Breast MRI |
| <input type="checkbox"/> CHRONIC MYELOGENOUS LEUKEMIA | All Bone Marrow Pathology PCR for BCR/ABL transcript | FISH for BCR/ABL |
| <input type="checkbox"/> COLORECTAL CANCER | K-ras Testing Preoperative CEA Level | Colonoscopy Report |
| <input type="checkbox"/> GASTRIC CANCER | EGD | HER2 Testing |
| <input type="checkbox"/> LUNG CANCER | EGFR/ALK Testing PDL Testing | Pulmonary Function Tests ROS-1 Testing |
| <input type="checkbox"/> LYMPHOMA | Flow Cytometry | Cytogenetics |
| <input type="checkbox"/> MELANOMA | BRAF Testing | NRAS Testing |
| <input type="checkbox"/> MYELOMA | 24 Hour Urine Serum Protein Electrophoresis Immunofixation | Serum Free Light Chains Beta 2 Microglobulin Bone Marrow Biopsy Pathology |
| <input type="checkbox"/> NEUROENDOCRINE TUMORS | Chromogranin A Level | 24 Hour Urine for 5HIAA |
| <input type="checkbox"/> RENAL/GYNECOLOGICAL/BLADDER CANCERS | CA125 Tumor Marker for Ovarian Cancer | |
| <input type="checkbox"/> PANCREATIC CANCER | ERCP (Endoscopic Retrograde Cholanigio-Pancreatography) Endoscopic Ultrasound | CA-19-9 Tumor Marker |
| <input type="checkbox"/> PROSTATE CANCER | PSA x 2 + years | |

Please fax requested information to Goshen Center for Cancer Care Intake Department at (574) 364-2488.
Please call (574) 364-2973 with any questions.

If above documents are not included please indicate reason _____



Goshen Physicians

ENDOCRINOLOGY

2024 Dorchester Ct #1, Goshen, IN 46526
(574) 537-1221

Our endocrinology team specializes in helping patients manage a wide range of chronic hormone-related disorders.

Meet our Endocrinology Team

Our endocrinology team has specialized training in the diagnosis and treatment of all endocrine system disorders.

Clinic Hours

Monday – Friday, 8:30 a.m. – 4:30 p.m.



Priyanka Mathias, MD
Endocrinology, Diabetes & Metabolism



Mallory Grossman, MSN, FNP-BC, RN
Endocrinology, Diabetes & Metabolism



**Catherine Steinkamp, MSN,
FNP-C, RN, CAPA**
Endocrinology, Diabetes & Metabolism



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Dr. Priyanka Mathias – Endocrinology

2024 Dorchester Ct, Ste 1 Goshen, IN 46526

Phone (574) 537-1221 | Fax (574) 537-1225

Referring Physician: _____

Office Address: _____

Office Phone #: _____ **Fax #:** _____

Patient Name: _____

Address: _____

Patient Contact: _____

Insurance Type: _____

1. Reason for Referral

- Manage and Treat
- Consult only
- Second Opinion

2. Diagnosis

- | | |
|--|---|
| <input type="checkbox"/> Type 1 DM | <input type="checkbox"/> Thyroid Cancer (see below) |
| <input type="checkbox"/> Type 2 DM | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Hypercalcemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Thyroid Nodules | |

3. Clinic Notes/Labs/Imaging

- Last 2 clinic notes
- Last 3 months of labs (relevant to referral done by referring provider)
- Last imaging (relevant to referral done by referring provider)
- All Thyroid labs – include FNAs for dx: Thyroid Nodules
- Thyroid CA
 - Pathology results/reports
 - Operative reports
 - All scans/imaging (Thyroid US, Pretreatment scans I123, Whole body scan, CT neck/chest/PET scans (if completed))



Goshen Physicians

ENT, SPEECH & AUDIOLOGY

Our ENT team provides advanced treatment and surgical care for patients with disorders of the head and neck, including ears, nose and throat as well as auditory disorders.

Meet our ENT, Speech & Audiology Team

Our specialists in ear, nose and throat medicine evaluate and treat adults and children with head and neck disorders.

Clinic Hours

Monday – Thursday, 8:00 a.m. – 5:00 p.m.

Friday, 8:00 a.m. – 12:00 p.m.



Savita Collins, MD
Otolaryngology
(Ear, Nose and Throat)



Darah Regal, AuD
Audiology



Alexa Liberi, MA, CCC-SLP
Speech-Language Pathologist



Karen Newcomer, MSN, FNP-BC
Otolaryngology
(Ear, Nose and Throat)



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ENT New Patient Referral Form

**Dr. Savita Collins, MD
Dr. Darah Regal, AuD
Alexa Liberi, MA, CCC-SLP**

Please complete this form and fax it, along with all pertinent medical records (progress notes, imaging, labs, operative reports, etc.) along with a copy of the patient's insurance card and demographics.

Patients will not be scheduled until we receive this completed form and medical records.

Name: _____ **Date of Birth:** _____

Phone #: _____

Address: _____

SS# _____

Insurance (Primary): _____ **(Secondary):** _____

Primary Language: _____

Interpreter Needed: Y N

Latex Allergy: Y N

REFERRING PROVIDER _____

Reason for referral (with ICD-10 codes):

Current Medications (including OTC):

Allergies: _____

Form completed by: _____ **Phone:** _____ **Date:** _____

RETURN FAX TO: (574) 534-2042

PHONE: (574) 534-2025

2012 S. Main Street Suite B, Goshen IN 46526



Goshen Physicians

GASTROENTEROLOGY

1615 Winsted Dr, Goshen, IN 46526
(574) 537-1625
1033 N Indiana Ave, Syracuse, IN 46567
(574) 537-5000

Our gastroenterology specialists treat a wide range of digestive disorders in the stomach, liver, intestines, esophagus and pancreas. We evaluate and treat a broad spectrum of digestive disorders, and offer in-office and outpatient procedures. The Goshen Surgery Center is a convenient option for many outpatient gastroenterology procedures.

Gastroenterology & Digestive Disorders Team

From initial screening and diagnosis to treatment and beyond, our gastroenterology specialists work together to deliver the best possible care that fits your needs.

Clinic Hours

Monday – Thursday, 8:00 a.m. – 5:00 p.m.

Friday, 8:00 a.m. – 12:00 p.m.



Ross Heil, DO



Sadat Rashid, MD
Interventional Gastroenterology



Melissa Larson, MSN, RN, FNP-C



**Amy Pointon, MSN, RN,
CNS, FNP- BC**



Lindsay Tomkiewicz, MSN, FNP-C



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New Patient Referral Form

- OFFICE CONSULT
 DIRECTACCESS FIBROSCAN*
 DIRECT ACCESS EGD
 DIRECT ACCESS COLONOSCOPY

In order to process a referral, fill out the form completely and please supply all the requested records. Referrals that do not have all of the completed information will be delayed in processing until all records are received.

*FIBBROSCAN referrals: include CBC,CMP or Hepatic Function Panel in the last 3 months, if available.

Please fax records to (574) 537-9384.

Patient Name: _____ **DOB:** _____ **AGE:** _____

Reason for referral (with ICD-10 codes): _____

Allergies: _____ **Latex Allergies? Y N**

Interpreter needed? Y N **Primary Language:** _____ **Date of Referral:** _____

Referring Provider: _____ **Office Number:** _____

Office Fax: _____ **Form completed by:** _____

- | | |
|---|---|
| <input type="checkbox"/> DEMOGRAPHICS (contact information, social security number and release of information forms) <input type="checkbox"/> INSURANCE INFORMATION (front and back card copies) <input type="checkbox"/> RECENT HEIGHT, WEIGHT AND CO-MORBIDITIES (required for screening colonoscopies) <input type="checkbox"/> MEDICATION LIST (with over-the-counter and herbal remedies) <input type="checkbox"/> LAST TWO OFFICE NOTES (from referring/primary physician) <input type="checkbox"/> PAST COLONOSCOPY REPORTS WITH PATHOLOGY <input type="checkbox"/> PAST EGD REPORTS WITH PATHOLOGY (include dilation reports, BRAVO pH or Impedance testing) | <input type="checkbox"/> GI RELATED IMAGING (CT scans, X-Rays, MRI, Ultrasounds, etc. in the past year) <input type="checkbox"/> PRIOR GASTROINTESTINAL SURGERY (include health system and surgeon) <input type="checkbox"/> GI RELATED TESTING (gastric emptying studies, anorectal or esophageal manometry, cookie swallows,esophogram, capsule endoscopy, etc.) <input type="checkbox"/> GI RELATED LABS: (CBC, CMP, PT/INR Liver profile, Hepatitis, Stool, IBD, etc. within the past year; Prometheus labs for IBD patients) <input type="checkbox"/> GI RELATED EMERGENCY ROOM REPORTS (abdominal pain, nausea/vomiting, diarrhea, swallowing difficulties, hematochezia, etc. within the past six months) |
|---|---|



Goshen Heart &
Vascular Center

**1855 S Main St, Goshen, IN 46526
(574) 533-7476**

**16605 IN-23, South Bend, IN 46635
(574) 533-7476**

**1033 N Indiana Ave, Syracuse, IN 46567
(574) 537-5000**

We work as a team to provide award-winning heart attack care while emphasizing prevention and healing. Our facilities are top-of-the-line—supporting our expert cardiologists, radiologists and surgeons in their minimally invasive procedures to restore blood flow throughout the body and help restore circulation to at-risk limbs.

Heart & Vascular Team

Our dedicated cardiologists work with electrophysiologists, radiologists, nurse practitioners, pulmonologists and surgeons to meet the needs of heart and vascular patients. Our multidisciplinary approach translates into regular daily and weekly group consultations, as well as an open office work environment.

Clinic Hours

Monday – Thursday, 8:00 a.m. – 5:00 p.m.

Friday, 8:00 a.m. – 12:00 p.m.



Charles Bower, MD, FACP
Interventional Radiology



Nathaniel Dew, MD, FACS
General Surgery, Vascular Surgery



Thomas Etter, MD
General Surgery



Djavid Hadian, MD
Electrophysiology



Farid Jalinous, MD, FACC, FSCAI
Interventional Cardiology



**Sreenivas Kamath, MD, FACC,
FSCAI**
Interventional Cardiology



Justin Lightburn, MD
Interventional Radiology



Blair MacPhail, MD, FACC
Interventional Cardiology



Abrar Sayeed, MD
Invasive Cardiology



Levi Smucker, MD
*Bariatric Medicine, General
Surgery, Vascular Surgery*



LeRoy Weaver, Jr, MD
Radiology



Jami Kamp, MSN, FNP-BC



Kim Kahler, MSN, ACNP-BC



Nickie Ralston, MSN, FNP-C



MEET OUR PROVIDERS

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Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Primary Insurance: _____ Policy#: _____ Group#: _____

Secondary Insurance: _____ Policy#: _____ Group#: _____

Ordering Physician: _____ Signature: _____

Primary Care Physician: _____ Send Copy To: _____

Fax Results To: _____

Diagnosis #1: _____ ICD-10 Code: _____

Diagnosis #2: _____ ICD-10 Code: _____

Diagnosis #3: _____ ICD-10 Code: _____

Diagnosis #4: _____ ICD-10 Code: _____

Tobacco Education Referral Form

Date of Referral: _____

Tobacco Cessation Education

- 1 to 4 education appointments as needed
One-on-one education provided by certified Tobacco Treatment Specialist

Other:

I hereby certify that the above patient is medically able to participate in Pulmonary Rehab.

PLEASE FAX COMPLETED FORM TO (574) 364-2531



Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Primary Insurance: _____ Policy#: _____ Group#: _____

Secondary Insurance: _____ Policy#: _____ Group#: _____

Ordering Physician: _____ Signature: _____

Primary Care Physician: _____ Send Copy To: _____

Fax Results To: _____

Diagnosis #1: _____ ICD-10 Code: _____

Diagnosis #2: _____ ICD-10 Code: _____

Diagnosis #3: _____ ICD-10 Code: _____

Diagnosis #4: _____ ICD-10 Code: _____

Cardiac Rehabilitation Referral Form

Date of Referral: _____ Date of qualifying event: _____

Cardiac Rehab

For required safety and admission qualifications, I authorize the following:

- Rehab staff to develop Individualized Treatment Plan/Exercise Rx for Medical Director to review and approve on admission to the program and every 30 days until discharge from program
• 6 Minute Walk Test pre and post program
• Cardiopulmonary Stress Test pre-program (as indicated by HF stratification)
• 12 Lead EKG within 3 months of the qualifying event

Intensive Cardiac Rehab (Ornish Lifestyle Medicine)

For required safety and admission qualifications, I authorize the Cardiac Rehab requirements listed above, in addition to:

- Labs pre program (if no draw in the past 3 months) and post program including lipids, HgbA1c and hsCRP

Diagnosis #3: _____ ICD-10 Code: _____

Diagnosis #4: _____ ICD-10 Code: _____

I hereby certify that the above patient is medically able to participate in Pulmonary Rehab.

PLEASE FAX COMPLETED FORM TO (574) 364-2531



Cardiology – New Patient Referral Form

Dr Farid Jalinous, Interventional Cardiology
Dr Sreenivas Kamath, Interventional Cardiology
Dr. Blair MacPhail, Interventional Cardiology
Dr. Abrar Sayeed, Invasive Cardiology
Dr. Djavid Hadian, Electrophysiology

Please complete this form and fax it, along with last office visit notes, Recent Medication list, recent labs, recent EKG/ECG, Echo’s, Stress Tests, Heart Catheterization, Arteriograms, Carotid Ultrasound, along with a copy of the patient’s insurance card and demographics.

If an echo/heart catheterization **is done outside of Goshen Health**, please make a copy on a CD. You can either mail a copy or send a copy with the patient.

Patients will not be scheduled until we receive this completed form along with medical records.

For urgent request please call our office to alert us after records have been faxed.

Name: _____ **Date of Birth:** _____

Phone #: _____

Address: _____

SS# _____

Insurance (Primary): _____ **(Secondary):** _____

Primary Language: _____

Interpreter Needed: Y N

REFERRING PROVIDER _____

Reason for referral (with ICD-10 codes):

RETURN FAX TO: (574) 533-7145 Attn. Sheila Pace Phone (574) 364-3921



New Patient Referral Form

Vascular Surgery:

Dr. Nathaniel Dew MD and Thomas Etter, MD

Vascular & Interventional Radiology:

Dr. Justin Lightburn MD and Dr. Charles Bower MD

Please complete this form and fax it, along with last office visit notes, lab testing, medication list, **Imaging, ultrasound (reports and outside films)** along with a copy of the patient's insurance card and demographics.

If imaging is done outside of Goshen Health, please make a copy on a CD or send through PACS. You can either mail a copy attention Sheila Pace or send a copy with the patient.

Patients will not be scheduled until we receive this completed form along with medical records.

Name: _____ Date of Birth: _____

Phone #: _____

Address: _____

SS# _____

Insurance (Primary): _____ (Secondary): _____

Primary Language: _____

Interpreter Needed: Y N

REFERRING PROVIDER _____

Reason for referral (with ICD-10 codes):

RETURN FAX TO: (574) 533-7145 Attn. Sheila Pace Phone (574) 364-3921



Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Primary Insurance: _____ Policy#: _____ Group#: _____

Secondary Insurance: _____ Policy#: _____ Group#: _____

Ordering Physician: _____ Signature: _____

Primary Care Physician: _____ Send Copy To: _____

Fax Results To: _____

Diagnosis #1: _____ ICD-10 Code: _____

Diagnosis #2: _____ ICD-10 Code: _____

Diagnosis #3: _____ ICD-10 Code: _____

Diagnosis #4: _____ ICD-10 Code: _____

Pulmonary Rehabilitation Referral Form

Date of Referral: _____

Pulmonary Rehab Program (up to 36 sessions, 3/week)

For required safety and admission qualifications, I authorize the following:

- Full PFT (if not done within the last 3 months).
• 12 lead EKG (if not done within the last 6 months).
• Initiate/titrate supplemental oxygen PRN during exercise.
• Rehab staff to develop Individualized Treatment Plan/Exercise Rx for Medical
• Director review/approval, initially and Q30 days until discharge.

Post COVID-19 Pulmonary Rehab Program (up to 36 sessions, 3/week)

For required safety and admission qualifications, I authorize the following:

- 12 lead EKG (if not done within the last 6 months).
• Initiate/titrate supplemental oxygen PRN during exercise.
• Rehab staff to develop Individualized Treatment Plan/Exercise Rx for Medical
• Director review/approval, initially and Q30 days until discharge.

I hereby certify that the above patient is medically able to participate in Pulmonary Rehab.

PLEASE FAX COMPLETED FORM TO (574) 364-2531



NeuroCare Center

GOSHEN PHYSICIANS

2832 Elkhart Rd. Goshen, IN 46526
(574) 537-0219

At the NeuroCare Center, our team offers a state-of-the-art neurologic diagnostic and treatment center for patients and their families residing in Northern Indiana and Southern Michigan. Providing advanced diagnostic procedures, MRI imaging, lab and infusion services, this center delivers the best care for patients available at a single location.

Nerve Disorders & Neurology Team

Our neurology team specializes in caring for patients with a wide range of conditions that affect the brain, spinal cord and nerves.

Clinic Hours

Monday – Friday, 8:00 a.m. – 4:30 p.m.



Liz Nafziger, MD
Neurology, Palliative Medicine



Leah Miller, MSN, FNP, RN-C
Neurology



Jillian Kimp, MSN, APRN, FNP-C
Neurology



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New Patient Referral Form

Service Request:

Consult **EMG/NCV** **EEG**

To ensure prompt scheduling, please include the following items with the referral form and fax to (574) 534-0435.

- Copy of patient's insurance card and demographic information.
- Office notes or records supporting the need for the requested service.
- Diagnostic imaging reports, if applicable.
- Lab reports, if applicable.
- Previous neurologist notes, if available.

URGENT REQUESTS, please call the office at (574) 537-0219 to speak with a provider.

Patient Name: _____ **DOB:** _____

Phone: _____

Primary Language: _____ **Interpreter Needed: Y N**

Reason for Referral: _____

Referring Provider: _____

Office Contact: _____

Office Phone: _____ **Fax:** _____

Thank you for the referral. We are committed to providing compassionate, comprehensive, quality care to all patients we serve.

RETURN FAX TO: (574) 534-0435

OFFICE PHONE: (574) 537-0219



Goshen Orthopedics

GOSHEN PHYSICIANS

1824 Dorchester Ct, Goshen, IN 46526

(574) 534-2548

1953 Waterfall Dr, Nappanee, IN 46550

(574) 534-2548

851 Parkway Ave, Elkhart, IN 46516

(574) 534-2548

1033 N Indiana Ave, Syracuse, IN 46567

(574) 534-2548

We take an all-inclusive approach to caring for patients bones, muscles and joints. From diagnosis and treatment through rehabilitation and follow-up care, we're dedicated to getting your patients back to enjoying life.

Goshen Orthopedics Team

Our entire team is here to help you heal!

We take the time to get to know your needs and lifestyle – offering surgical and non-surgical solutions that reduce pain and put you on the road to recovery.

Clinic Hours

Monday, 6:00 a.m. – 5:00 p.m.

Tuesday, 8:00 a.m. – 5:00 p.m.

Wednesday, 8:00 a.m. - 5:00 p.m.

Thursday, 7:00 a.m. - 5:00 p.m.

Friday, 6:00 a.m. – 5:00 p.m.



Christopher Owens, MD
Orthopedic Surgery and Sports Medicine



Bryan Boyer, MD
Orthopedic Surgery



Kevin Houseman, DPM
Podiatry



Andrew Kalin, MD
Pain Management



Scott Swanson, MD
Orthopedic Hand Surgery



Eric Brown, MSN, NP-C
Orthopedics and Sports Medicine



Jeffery Lain, FNP-C, CRNFA
Orthopedics and Sports Medicine



Tracy VanderReyden, MSN, FNP-BC
Orthopedics and Sports Medicine



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Orthopedics – New Patient Referral Form

C. Owens, MD | S. Swanson, MD | B. Boyer, MD | A. Kalin, MD
K. Houseman, DPM | E. Brown, NP | J. Lain, NP

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Primary Insurance: _____ Policy#: _____ Group#: _____

Secondary Insurance: _____ Policy#: _____ Group#: _____

Ordering Physician: _____ Signature: _____

Primary Care Physician: _____ Send Copy To: _____

Fax Results To: _____

Diagnosis #1: _____ ICD-10 Code: _____

Diagnosis #2: _____ ICD-10 Code: _____

Diagnosis #3: _____ ICD-10 Code: _____

Diagnosis #4: _____ ICD-10 Code: _____

Request for Opinion

Consult Request to: _____

A request for opinion and consult for the above-named patient is being sent to Goshen Orthopedics for the following reasons:

The physician requesting this opinion understands that the consulting physician may initiate treatment or perform medically necessary diagnostics for this patient. The consulting physician will send the requesting physician an opinion and plan of care.

****Please sign and return by fax to 574-534-3622****

This portion to be completed by Goshen Orthopedics

Appointment Date: _____

Confirmation fax sent to requesting physician: Today's date _____

Attending Physician: _____

(Please print)



Goshen Rehabilitation

1824 Dorchester Ct. Ste. B, Goshen, IN 46526

(574) 537-0962

1953 Waterfall Dr. Ste. B, Nappanee, IN 46550

(574) 773-3038

1033 N. Indiana Ave. Ste C, Syracuse, IN 46567

(574) 457-2213

Following an injury, illness, surgery or trauma, Goshen Rehabilitation can help your patients (adults and children) achieve their highest potential. We offer a complete range of rehabilitative care, including physical therapy, occupational therapy and speech therapy.



MEET OUR PROVIDERS

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Goshen Physicians

SLEEP & ALLERGY MEDICINE

2417 Berkshire Dr. Goshen, IN 46526
(574) 534-9911

Your patients can get the relief they desire with treatment from our specialists at Goshen Physicians Sleep & Allergy Medicine. Our approach to care starts by looking at the real reasons for your patients' restless sleep or trouble inhaling and exhaling a full dose of air. We then design a treatment plan specific to your patients' needs and preferences.

Sleep & Allergy Medicine Care Team

Goshen Physicians Sleep & Allergy Medicine offers a full range of treatment options, including immunotherapy injections, environmental controls and lifestyle changes. Our team of experts, including a board certified sleep specialist, can help you get the relief you want and the sleep you need.

Clinic Hours

Monday – Thursday, 8:00 a.m. – 5:00 p.m.

Friday, 8:00 a.m. – 12:00 p.m.



Sultan Niazi, MD
*Critical Care Medicine, Internal
Medicine, Sleep & Allergy
Medicine*



Katherine O'Toole, NP-C
Sleep & Allergy Medicine



Deborah Risa, NP-C
Sleep & Allergy Medicine



**Stephanie Cross, MSN,
APRN, AGNP-C**
Sleep & Allergy Medicine



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Goshen Physicians

SLEEP & ALLERGY MEDICINE

2417 S Berkshire Drive
Goshen, IN 46526

Phone: (574)534-9911
Fax: (574) 534-6915

Sleep & Allergy New Patient Referral Form

Sultan Niazi, MD

Deborah Risa, NP-C

Katherine O'Toole, NP-C

Stephanie Cross, MSN, APRN, AGNP-C

Name: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Date of Birth: _____

Referring Provider: _____

Phone: _____ Fax: _____

Insurance: _____

Reason for Consult: _____

- SLEEP CONSULT- evaluate and treat
- SLEEP STUDY
- ALLERGY CONSULT
- ALLERGY TESTING

In addition to this form please send the following:

- Demographic sheet
- Office notes
- Insurance card(s)
- Any sleep studies (if patient has had prior studies)



Goshen Physicians

UROLOGY

1808 Charlton Ct, Goshen, IN 46526
(574) 533-8420

Our urology team specializes in diagnosing and treating problems with the male and female urinary tract and male reproductive organs.

Urology Team

Our urology team is highly trained in diagnosing and treating diseases and disorders of the urinary tract system.

Clinic Hours

Monday, Tuesday & Thursday, 9:00 a.m. – 5:00 p.m.

Friday, 9:00 a.m. – 12:00 p.m.



Anthony Gauthier, Jr., MD
Urology



**Morgan Danielson, MSN, APRN,
FNP-BC, CUNP**
Urology



Oksana Jumanov, MSN, FNP-BC
Urology



MEET OUR PROVIDERS

Learn more about our providers and their practices in our video library.

Urology New Patient Referral Form
Dr. Anthony Gauthier, Jr., MD
Morgan Danielson, MSN, APRN, FNP-BC, CUNP
Oksana Jumanov, MSN, FNP-BC

Name: _____ **Date of Birth:** _____

Phone #: _____

Address: _____

SS# _____

Insurance (Primary): _____ **(Secondary):** _____

Primary Language: _____

Interpreter Needed: Y N

Latex Allergy: Y N

REFERRING PROVIDER _____

Reason for referral (with ICD-10 codes):

Current Medications (including OTC):

Allergies:

Form Completed By: _____

Phone: _____ **Date:** _____



Goshen Physicians

OB/GYN

We know women's health needs are ever-changing and complex. That's why we provide comprehensive care for women of all ages. Our OB/GYN team provides a continuum of care for women from adolescence and pregnancy through menopause and beyond. We offer services ranging from prenatal care and family planning to hormone replacement therapy and everything in between.

OB/GYN Team

Our OB/GYN team provides a continuum of care for women from adolescence and pregnancy through menopause and beyond. We offer services ranging from prenatal care and family planning to hormone replacement therapy and everything in between.

Clinic Hours

Monday – Thursday, 8:00 a.m. – 5:00 p.m.

Friday, 8:00 a.m. – 4:00 p.m.



Sharrell Gibson, MD
Obstetrics & Gynecology



Rebecca Gindelberger, DO
Obstetrics & Gynecology



James Lindemulder, DO
Obstetrics & Gynecology



Lorraine Weaver, MD
Obstetrics & Gynecology



**Danae Bell, MSN, FNP-BC,
RNC-OB**
Obstetrics & Gynecology



Hollyann Lambdin, ACNP, BC
Obstetrics & Gynecology



**Kelly Simpson, MSN,
WHNP, RNC-OB**
Obstetrics & Gynecology



**Teneesa Stuckey, MSN,
WHNP-BC, NEA-BC,
C-ONQS**
Obstetrics & Gynecology



MEET OUR PROVIDERS

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Goshen Physicians

OB/GYN

1122 Professional Dr.
Goshen, IN. 46526

Phone: (574) 533-0560
Fax: (574)-533-1716-Fax

Consultation / Referral Request Form

Date: _____ Incoming Request Outgoing Request

Referring Provider: _____

Person Calling: _____

Contact Phone: _____ Fax: _____

Patient Information

Name: _____ Date of Birth: _____

Phone #: _____

Address: _____

SS# _____

Insurance (Primary): _____ (Secondary): _____

Primary Language: _____

Interpreter Needed: Y N

Reason for referral: Consult Only Consult and Treat Transfer of Care

Requested Provider: _____

Appt Date/Time: _____



Goshen Wound Center

2006 S Main St. Goshen, IN 46526
(574) 364-4560

Our multidisciplinary, integrated approach at Goshen Wound & Hyperbaric Center offers patients a team of specially trained doctors, nurses and technicians. For patients suffering from diabetic, neuropathic or pressure ulcers, venous insufficiency, traumatic wounds, surgical wounds, vasculitis, burns or any other chronic, non-healing wound – we can help. At Goshen Wound & Hyperbaric Center, we treat a wide range of wounds associated with complications from diabetes, vascular disorders and trauma.

Wound Care

Our wound care doctors, nurses and technicians are specially trained in the latest treatments and technology available.

Clinic Hours

Monday – Friday, 8:00 a.m. – 4:30 p.m.



Nathaniel Dew, MD, FACS
General Surgery, Vascular Surgery



Daniel Diener, MD
General Surgery, Vascular Surgery



Thomas Etter, MD
General Surgery



Kevin Gerig, MD, FACS
General Surgery, Vascular Surgery



Kevin Houseman, DPM
Podiatry



Mark Ranzinger, MD, FACS
General Surgery, Thyroid Surgery



Jonathan Schrock, MD
Pain Management



Levi Smucker, MD
Bariatric Medicine, General Surgery, Vascular Surgery



MEET OUR PROVIDERS

Learn more about our providers and their practices in our video library.



Goshen Wound Center
2006 S Main St Suite B
Goshen, IN 46526

Goshen Wound Center – New Patient Referral Form

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Primary Insurance: _____ Policy#: _____ Group#: _____

Secondary Insurance: _____ Policy#: _____ Group#: _____

Ordering Physician: _____ Signature: _____

Primary Care Physician: _____ Send Copy To: _____

Fax Results To: _____

Diagnosis #1: _____ ICD-10 Code: _____

Diagnosis #2: _____ ICD-10 Code: _____

Diagnosis #3: _____ ICD-10 Code: _____

Diagnosis #4: _____ ICD-10 Code: _____

FAX REFERRAL FORM

Date: _____

Does the patient have an open wound? Yes No

Is the patient an inpatient in a Skilled Nursing Facility? Yes No

If yes, is the patient under a Part A Medicare stay? Yes No

Wound #1

- Right Leg
- Left Leg
- Right Foot
- Left Foot
- Coccyx/Sacrum
- Other: _____

Wound #2

- Right Leg
- Left Leg
- Right Foot
- Left Foot
- Coccyx/Sacrum
- Other: _____

Please send a copy of patient's History and Physical, a recent Progress Note, most recent Labs, Vascular Studies, X-ray/imaging, current problems and Medication List, a current Face Sheet, and Insurance Card when faxing referral. Thank you.

FOR OFFICE USE ONLY

Appointment Date: _____

Appointment Time: _____

Confirmation Call Made: _____