



2024 GOSHEN HEALTH

# Provider Guide

For the most current information visit  
[goshenhealth.com/quick-guide](https://goshenhealth.com/quick-guide)



Goshen Health

04/24/24 16:28:01

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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; palliative care physicians; 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*



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



**Judith Huff, NP**  
*Medical Oncology*



**Kennedy Iheanacho, MD**  
*Internal Medicine, Hematology  
Oncology, Medical Oncology*



**Ebenezer Kio, MD**  
*Hematology Oncology, Medical  
Oncology*



**Katarina Leckova, MD**  
*Internal Medicine, Hematology  
Oncology, Medical Oncology*



**Liz Nafziger, MD**  
*Neurology, Palliative Medicine*



**Jonathan Newhall, PA-C**  
*Medical Oncology*



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

**Surgical Oncology**



**Muhammad Bostaji, MD**  
*Interventional Pulmonology*



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



**Fiona Denham, MD, FACS**  
*Breast Surgical Oncology, Surgical Oncology*



**Ronald Downs, MD, FACS**  
*Plastic Surgery*



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



**Rachel Macias, MD**  
*Plastic Surgery*



**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*



**Elise Sharkey, PA**  
*Surgical Oncology*



**Pamela Stone, MD, FACOG, FACS**  
*Gynecologic Oncology*



**Patrick Viscardi, MD**  
*Plastic Surgery*



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

### Radiation Oncology



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



**Irina Sparks, MD**  
*Radiation Oncology*



**Houman Vaghefi, MS, MD, PhD**  
*Radiation Oncology*



**James Wheeler, MD, PhD**  
*Radiation Oncology*

### Integrative Care



**Maria Brown, RD, CD**  
*Oncology Nutrition*



**Rita Gingrich, MSW, LCSW, OSW-C**  
*Mind-Body Counselor*



**LaToya Lewis, ND**  
*Naturopathic Medicine*



**Maricel Lopez-Colon, RD, LDN**  
*Oncology Nutrition*



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



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



**Bethany Swope, MS Ed, LMFT**  
*Mind-Body Counselor*



## MEET OUR PROVIDERS

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



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	
<input type="checkbox"/>	Referring provider's most recent office note pertaining to diagnosis
<input type="checkbox"/>	Imaging from past year – Including CT, PET, MRI, Ultrasound, Nuclear Medicine, MUGA/Echo
<input type="checkbox"/>	Most recent pathology report as well as pathology report from initial diagnosis
<input type="checkbox"/>	Labs from past year
<input type="checkbox"/>	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



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.



**Lily Kwatampora, MD**

*Endocrinology, Diabetes & Metabolism*



**Priyanka Mathias, MD**

*Endocrinology, Diabetes & Metabolism*



### MEET OUR PROVIDERS

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

**Dr. Lily Kwatampora- Endocrinology**

2012 S. Main St. Ste. C

Goshen, IN 46526

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

Referring Physician \_\_\_\_\_

Office Address \_\_\_\_\_

Office Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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	<input type="checkbox"/>	

**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))

# 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.

## 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)*



**Alexa Liberi, MA, CCC-SLP**

*Otolaryngology (Ear, Nose and Throat)*



**Darah Regal, AuD**

*Otolaryngology (Ear, Nose and Throat)*



### MEET OUR PROVIDERS

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



# Goshen Physicians

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: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Latex Allergy: Yes: \_\_\_\_\_ No: \_\_\_\_\_

**REFERRING PROVIDER** \_\_\_\_\_

Reason for referral (with ICD-10 codes):

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Current Medications (including OTC):

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Allergies: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

RETURN FAX TO: (574) 534-2042

PHONE: (574) 534-2025

Office: 2012 S. Main Street Suite B, Goshen IN 46526



Goshen Physicians

GASTROENTEROLOGY

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



Salim Jaffer, MD



Melissa Larson, MSN, RN, FNP-C



Amy Pointon, MSN, RN, SNC, FNP-BC



Sadat Rashid, MD

*Interventional Gastroenterology*



Lindsay Tomkiewicz, MSN, FNP-C



### MEET OUR PROVIDERS

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# New Patient Referral Form

- OFFICE CONSULT**     
  **DIRECT ACCESS 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? YES or NO

Interpreter needed? YES or NO    Primary Language: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Office Number: \_\_\_\_\_

Office Fax: \_\_\_\_\_ Form completed by: \_\_\_\_\_

**DEMOGRAPHICS** (contact information, social security number and release of information forms)

**INSURANCE INFORMATION** (front and back card copies)

**RECENT HEIGHT, WEIGHT AND CO-MORBIDITIES** (required for screening colonoscopies)

**MEDICATION LIST** (with over-the-counter and herbal remedies)

**LAST TWO OFFICE NOTES** (from referring/primary physician)

**PAST COLONOSCOPY REPORTS WITH PATHOLOGY**

**PAST EGD REPORTS WITH PATHOLOGY** (include dilation reports, BRAVO pH or Impedance testing)

**GI RELATED IMAGING** (CT scans, X-Rays, MRI, Ultrasounds, etc. in the past year)

**PRIOR GASTROINTESTINAL SURGERY** (include health system and surgeon)

**GI RELATED TESTING** (gastric emptying studies, anorectal or esophageal manometry, cookie swallows, esophogram, capsule endoscopy, etc.)

**GI RELATED LABS:** (CBC, CMP, PT/INR Liver profile, Hepatitis, Stool, IBD, etc. within the past year; Prometheus labs for IBD patients)

**GI RELATED EMERGENCY ROOM REPORTS** (abdominal pain, nausea/vomiting, diarrhea, swallowing difficulties, hematochezia, etc. within the past six months)





Goshen Heart &  
Vascular Center

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, FACR**  
*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*



**Kim Kahler, MSN, ACNP-BC**



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



**Jami Kamp, MSN, FNP-BC**



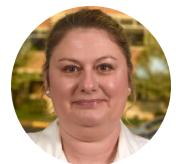
**Ram Khattri Chettri, MBA, MS,  
MATS, FNP-C**



**Justin Lightburn, MD**  
*Interventional Radiology*



**Blair MacPhail, MD, FACC**  
*Interventional Cardiology*



**Nickie Ralston, MSN, FNP-C**



**Abrar Sayeed, MD**  
*Invasive Cardiology*



## **MEET OUR PROVIDERS**

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



Patient Name _____	Ordering Physician Signature _____
Date of Birth _____ Social Security _____	Ordering Physician _____
Address _____	
City _____ State _____ Zip _____	Primary Care Physician _____
Telephone # _____	Send Copy To _____
	Fax Results To _____
Primary Insurance _____	
Primary Policy # _____ Group # _____	Diagnosis #1 _____ ICD-10 Code _____
	Diagnosis #2 _____ ICD-10 Code _____
Secondary Insurance _____	Diagnosis #3 _____ ICD-10 Code _____
Secondary Policy # _____ Group # _____	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: \_\_\_\_\_

**PLEASE FAX COMPLETED FORM TO  
574-364-2531**



Form with fields for Patient Name, Date of Birth, Social Security, Address, City, State, Zip, Telephone #, Primary Insurance, Primary Policy #, Group #, Secondary Insurance, Secondary Policy #, Group #, Ordering Physician Signature, Ordering Physician, Primary Care Physician, Send Copy To, Fax Results To, Diagnosis #1-4, 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 #1 ICD-10 Code
Diagnosis #2 ICD-10 Code

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

PLEASE FAX COMPLETED FORM TO
574-364-2531



1855 S. Main St. Suite A  
Goshen IN, 46526

**Cardiology- New Patient Referral Form**

**Dr Farid Jalinous**, Interventional Cardiology  
**Dr Sreenivas Kamath**, Interventional Cardiology  
**Dr. Blair MacPhail**, Interventional Cardiology  
**Dr. Abrar Sayeed**, General 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 Yes: \_\_\_\_\_ No: \_\_\_\_\_

**REFERRING PROVIDER:** \_\_\_\_\_

Reason for referral (with ICD---10 codes):  
\_\_\_\_\_

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



**1855 S. Main St. Suite A  
Goshen IN, 46526  
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.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

Address:  
\_\_\_\_\_

SS#: \_\_\_\_\_

Insurance: (Primary) \_\_\_\_\_ (Secondary) \_\_\_\_\_

Primary Language: \_\_\_\_\_

Interpreter needed Yes: \_\_\_\_\_ No: \_\_\_\_\_

**REFERRING PROVIDER:** \_\_\_\_\_

Reason for referral (with ICD—10 codes):  
\_\_\_\_\_

**RETURN FAX TO: (574) 533-7145 ATTENTION: Sheila Pace  
Sheila Pace/Heart & Vascular Center Referral Specialist-574-364-3921**

Patient Name _____	Ordering Physician Signature _____
Date of Birth _____ Social Security _____	Ordering Physician _____
Address _____	
City _____ State _____ Zip _____	Primary Care Physician _____
Telephone # _____	Send Copy To _____
	Fax Results To _____
Primary Insurance _____	
Primary Policy # _____ Group # _____	Diagnosis #1 _____ ICD-10 Code _____
	Diagnosis #2 _____ ICD-10 Code _____
Secondary Insurance _____	Diagnosis #3 _____ ICD-10 Code _____
Secondary Policy # _____ Group # _____	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

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.



**Beth Jones, RN, MSN, FNP-BC**

*Neurology*



**Leah Miller, RN-C, MSN, FNP**

*Neurology*



**Liz Nafziger, MD**

*Neurology, Palliative Medicine*



**Jody Neer, MD**

*Neurology*



### MEET OUR PROVIDERS

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

**New Patient Referral Form**  
**NeuroCare Center 2832 Elkhart Rd, Goshen IN, 46526**

**Service Request:**    Consult    EMG/NCV    EEG

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**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.**

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Interpreter Need?   Yes: \_\_\_\_\_   No: \_\_\_\_\_

Reason for Referral \_\_\_\_\_

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Referring Provider: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Office Phone: \_\_\_\_\_   Office Fax: \_\_\_\_\_

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**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

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 – Friday, 6:00 a.m. – 5:00 p.m.



**Eric Brown, MSN, NP-C**

*Orthopedic Surgery and Sports  
Medicine*



**Quentin Cave, LAT, ATC**

*Athletic Training*



**Maritza Chavez Stahly, MAT, LAT,  
ATC**

*Athletic Training*



**Nicholas DeFauw, DO**

*Sports Medicine*



**Alexis Holthues, MS, LAT, ATC**

*Athletic Training*



**Kevin Houseman, DPM**

*Podiatry*



**Jeffery Lain, FNP-C, CRNFA**

*Orthopedic Spine Surgery,  
Orthopedic Surgery and Sports  
Medicine*



**Lindsay Neff, MSN, FNP-C, ONP-C**

*Orthopedic Surgery and Sports  
Medicine*



**Christopher Owens, MD**

*Orthopedic Surgery and Sports  
Medicine*



**Alex Serwatka, LAT, ATC**

*Athletic Training*



**Scott Swanson, MD**

*Orthopedic Hand Surgery*



## MEET OUR PROVIDERS

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

Patient Name _____  Date of Birth _____ Social Security # _____  Address _____  City _____ State _____ Zip _____  Telephone # _____  Primary Insurance _____  Primary Policy # _____ Group # _____  Secondary Insurance _____  Secondary Policy # _____ Group # _____	<div style="background-color: yellow; padding: 2px;"><b>Ordering Physician Signature</b> _____</div> Ordering Physician (Print) _____ 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 _____
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### 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)

1824 Dorchester Ct., Suite A, Goshen, IN 46526  
Ph. (574) 534-2548 | Fax (574) 534-3622

K. Carlson, DO    C. Owens, MD  
N. DeFauw, DO    K. Houseman, DPM  
E. Brown, NP    J. Lain, NP    L. Neff, NP



Goshen Rehabilitation



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

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



Goshen Physicians

SLEEP & ALLERGY MEDICINE

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*



## MEET OUR PROVIDERS

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Goshen Physicians

SLEEP & ALLERGY MEDICINE

REFERRAL FORM

Sultan Niazi, MD, Deborah Risa, NP-C, Katherine O'Toole, NP-C

2417 S Berkshire Drive

Goshen, IN 46526

Phone: (574)534-9911

Fax: (574) 534-6915

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

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.



**Kristin Abbs, MSN, APRN, FNP-C,  
FNP-BC**

*Urology*



**Jeffrey Bolduan, MD**

*Urology*



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

*Urology*



**Anthony Gauthier, Jr., MD**

*Urology*



## MEET OUR PROVIDERS

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**Urology – New Patient Referral Form**  
**Dr. Jeffrey Bolduan, MD**  
**Kristin Abbs, NP**

Please complete this form and fax it, along with all **pertinent medical records** (progress notes, imaging, PSA, labs, operative reports, pathology) 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 Yes: \_\_\_\_\_ No: \_\_\_\_\_

Latex Allergy Yes: \_\_\_\_\_ No: \_\_\_\_\_

**REFERRING PROVIDER:** \_\_\_\_\_

Reason for referral (with ICD---10 codes):  
\_\_\_\_\_

Current Medications (including OTC):  
\_\_\_\_\_

Allergies:  
\_\_\_\_\_

Form completed by: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**RETURN FAX TO: (574) 534-5722**

**PHONE: (574) 533-8420**

**Office: 1615 Winsted Drive, Suite 4**

**Goshen, IN 46526**





Goshen Physicians

CENTER FOR WEIGHT REDUCTION

At Goshen Physicians Center for Weight Reduction, our team provides the tools patients need to meet their weight loss goals. These include dedicated specialists equipped with the most advanced research and technology.

## Bariatrics & Managed Weight Team

You can lose weight, and we can help! Our caring and compassionate weight loss experts support you every step of the way. Everyone is deeply committed to the art of caring for you.

### Clinic Hours

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

Friday, 8:00 a.m. – 4:00 p.m.



**Mallory Grossman, MSN, BSN,  
FNP, RN**

*Bariatric Medicine*



**Kathleen Meier, RNC, MSN, ANP**

*Bariatric Medicine*



**Denise Murphy, MD, FACS**

*Bariatric Medicine, General  
Surgery*



**Catherine Wesson, MSN, FNP-C,  
RN, CAPA**

*Bariatric Medicine*



### 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, Indiana 46526  
(574) 364-4560

Hours of Operation Monday - Friday 8 am - 5 pm  
To Schedule Please Call (574) 364-4560  
Fax Order To (574) 364-4561

Appointment Date and Time: \_\_\_\_\_

Patient Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone # \_\_\_\_\_  
 Primary Insurance \_\_\_\_\_  
 Primary Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Secondary Insurance \_\_\_\_\_  
 Secondary Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Ordering Physician Signature \_\_\_\_\_  
 Ordering Physician \_\_\_\_\_  
 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**

Today's 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 (specify): \_\_\_\_\_

**Wound #2**

- Right Leg
- Left Leg
- Right Foot
- Left Foot
- Coccyx / Sacrum

**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: \_\_\_\_\_



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.



**Danae Bell, MSN, FNP-BC, RNC-OB**

*Obstetrics & Gynecology*



**James Frimpong, MD, FACOG**

*Obstetrics & Gynecology*



**Sharrell Gibson, MD**

*Obstetrics & Gynecology*



**Rebecca Gindelberger, DO**

*Obstetrics & Gynecology*



**Hollyann Lambdin, ACNP, BC**

*Obstetrics & Gynecology*



**James Lindemulder, DO**

*Obstetrics & Gynecology*



**Carissa May, MD**

*Obstetrics & Gynecology*



**Kelly Simpson, MSN, WHNP, RNC-OB**

*Obstetrics & Gynecology*



**Lorraine Weaver, MD**

*Obstetrics & Gynecology*



## MEET OUR PROVIDERS

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



## Consultation / Referral Request Form

Date: \_\_\_\_\_ Incoming Request  Outgoing Request

Referring Dr.: \_\_\_\_\_

Person Calling: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient Information:

Name: \_\_\_\_\_  
First Middle Last

DOB: \_\_\_\_\_ SS# \_\_\_\_\_ Language \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alternate #: \_\_\_\_\_

Insurance: \_\_\_\_\_

Consult Only

Consult and Treat

Transfer of care

Reason for referral:

Requested Provider \_\_\_\_\_ Appt Date/Time \_\_\_\_\_



Goshen Wound Center



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*



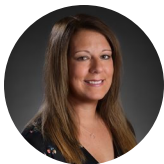
**Jonathan Schrock, MD**

*Pain Management*



**Levi Smucker, MD**

*General Surgery*



**Tracy Vander Reyden, NP**

*General Surgery*



## MEET OUR PROVIDERS

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**Goshen Wound Center**

2006 S Main St Suite B  
Goshen, Indiana 46526  
(574) 364-4560

Hours of Operation Monday - Friday 8 am - 5 pm  
To Schedule Please Call (574) 364-4560  
Fax Order To (574) 364-4561

Appointment Date and Time: \_\_\_\_\_

Patient Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone # \_\_\_\_\_  
 Primary Insurance \_\_\_\_\_  
 Primary Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Secondary Insurance \_\_\_\_\_  
 Secondary Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Ordering Physician Signature \_\_\_\_\_  
 Ordering Physician \_\_\_\_\_  
 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**

Today's 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 (specify): \_\_\_\_\_

**Wound #2**

- Right Leg
- Left Leg
- Right Foot
- Left Foot
- Coccyx / Sacrum

**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: \_\_\_\_\_