UC Health

Patient Referral Request Form - Oral Maxillofacial Surgery

UC Health Physician Network / Ambulatory Services
Cincinnati, Ohio

Patient Information (to be completed by the referring provider's office)

UC Health MRN (if available)	*First and Last Name	
*Gender at Birth	*Date of Birth (MM/DD/YYYY)	
Home address		
City	State	Zip Code
*Primary Phone Number	Home ☐ Mobile ☐ Work ☐	
*Primary Insurance Provider	Member ID	Group ID
Secondary Insurance Provider (if applicable)	Member ID	Group ID

If patient has no insurance, check this box. ☐

(Please provide a copy of patient's insurance card - front and back)

Patient Referral Information

*Referral diagnosis/chief complaint:

Purpose of referral:

Specific clinical questions or comments regarding the patient and condition(s):

Patient Referral Services Requested

DOES THE PATIENT HAVE A COPY OF THEIR X-RAYS? ☐ YES ☐ NO (name and DOB must be on film)

Patient being referred for evaluation and extractions of (please circle all that apply):

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Name of UC Health clinician(s) you'd like to refer the patient to (if applicable):

Note: Requesting a specific provider may cause delays in appointment scheduling.

Information About Referring Clinician

*Referring Clinician Name		NPI
*Practice Name		
Office Address		
City	State	Zip Code
Phone Number	Fax	
E-mail address		

Referral Submission Instructions

To support timely referral processing and scheduling, please submit the completed referral to the **Referral Management Team**:
Fax: 513-475-8721 | **Email:** Outpatient-Referrals@uchealth.com

For clinical questions or assistance with supporting documentation, please contact the **Oral Surgery Team**:
Phone: 513-475-8783 | **Email:** UCHealthOMFS@uchealth.com