UC Health

# *Ambulatory Services Referral Form*

Please complete, print and fax to 513-584-2599.

Thank you for your referral to UC Health Ambulatory Services. Referrals to UC Health can be made by completing the form below and faxing to 513-584-2599 with a brief synopsis of patient history.

**Referring Provider Information**

| | | | |
|---|---|---|---|
| Referring Provider | | | Date *(Month DD, YYYY)* |
| Practice Name | | Referring Physician NPI | |
| Office Address | | | City |
| State | ZIP Code | | |
| Phone | Fax | Specialty Referral to: | |
| Location: UCMC Campus | West Chester Campus | Other: | |

**Patient Contact Information**

| | | | |
|---|---|---|---|
| Patient Name *(First, Middle, Last)* | | | Sex ☐ Male ☐ Female |
| Birth Date *(Month DD, YYYY)* | | Patient Email (if available) | |
| Address | | | City |
| State | ZIP Code | | Country (optional) |
| *HOME PHONE | *ALTERNATE PHONE Mobile Work Other | Parent Name (if minor) | |
| Maiden Name (If known) | | Spouse First Name (optional) | |
| Patient Insurance Information (please send a copy of front/back of card) | | Does the patient need an interpreter? Yes No | If yes, what language? |
| APPOINTMENT REQUEST: Urgent/First Available | | Does the patient have other special needs? | If yes, what needs? |
| Clinical question to be answered | | Indication/Diagnosis | Special Request |
| Indicate if records in EPIC or Care Anywhere | | YES | NO |

***FORM WILL NOT BE PROCESSED WITHOUT NECESSARY PATIENT CONTACT INFORMATION**