UC Health

Patient Referral Request Form

UC Health Physician Network / Ambulatory Services
Cincinnati, Ohio

Patient Information (to be completed by referring clinician'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 _____
(If applicable) Secondary Insurance Provider _____ 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: _____
List any specific clinical questions or comments you have regarding the patient and their condition(s): _____

Patient Referral Services Requested

- ☐ ACUPUNCTURE
- ☐ ALLERGY
- ☐ AQUATIC THERAPY
- ☐ AUDIOLOGY
- ☐ BARIATRIC SURGERY
- ☐ BENIGN HEMATOLOGY
- ☐ BLOOD & MARROW TRANSPLANT (BMT)
- ☐ CARDIOLOGY
- ☐ COLORECTAL SURGERY
- ☐ DERMATOLOGY
- ☐ Electromyography (EMG)
- ☐ ENDOCRINOLOGY
- ☐ ENT (OTOLARYNGOLOGY)
- ☐ GENERAL SURGERY
- ☐ GI OFFICE VISIT/CONSULT
- ☐ GI PROCEDURES
- ☐ HAND SURGERY
- ☐ HEPATOLOGY
- ☐ INFECTIOUS DISEASE
- ☐ KIDNEY TRANSPLANT
- ☐ LIVER TRANSPLANT
- ☐ LUNG CANCER SCREENING
- ☐ NEPHROLOGY
- ☐ NEUROLOGY
- ☐ NEUROSURGERY
- ☐ OB-GYN
- ☐ OCCUPATIONAL THERAPY
- ☐ ONCOLOGY/SOLID TUMOR
- ☐ OPHTHALMOLOGY
- ☐ ORAL MAXILLOFACIAL SURGERY
- ☐ ORTHOPEDIC SURGERY
- ☐ PAIN CLINIC
- ☐ PHYSICAL MEDICINE REHAB
- ☐ PHYSICAL THERAPY
- ☐ PLASTIC SURGERY
- ☐ PODIATRY
- ☐ PSYCHIATRY
- ☐ PULMONOLOGY
- ☐ RHEUMATOLOGY
- ☐ SLEEP MEDICINE
- ☐ SPEECH THERAPY
- ☐ SURGICAL ONCOLOGY
- ☐ UROGYNECOLOGY
- ☐ UROLOGY
- ☐ VASCULAR
- ☐ WOUND CLINIC
- ☐ OTHER

_____
_____

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 _____

To submit a referral form via secure fax, send it to 513-584-2599.
For questions or comments, email UC Health's Patient Referral Team at Outpatient-Referrals@uchealth.com.