UC Health

Ambulatory Services Referral Form

Please complete, print and fax 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 Physician Information

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

Patient 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