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**