



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 <input type="checkbox"/> Male <input type="checkbox"/> 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**