

OHC Request for Patient Medical Records



Referring Physician: _____

Fax Number: _____ Office Number: _____

Patient's Name: _____ Date of Birth: _____

Diagnosis: _____ Primary Care Physician: _____

Patient Scheduled with OHC Physician: _____

Date and Location to be Seen: _____

We Need the Following Records for all Blood Cancers:

<input type="checkbox"/> All Recent Progress Notes	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> All Recent Consult Notes	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> All Pathology	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> All Bone Marrow Findings and Appropriate Labs	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Chromosome Analysis	<input type="checkbox"/> Received by OHC

OTHER OR PENDING RESULTS

Fax Documents to 513-762-2483 by This Date: _____

OHC Team Member Requesting Records: _____

*Thank you for choosing OHC. If you have any questions,
please contact Medical Records at 1-888-649-4800.
5053 Wooster Road, Cincinnati, Ohio 45226*

NOTE: The information contained in these materials is confidential and intended only for the designated recipient. If you have received this fax in error, you are hereby notified that review, dissemination, distribution or copying of this information is