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 GYNECOLOGIC ONCOLOGY PATIENTS

____ Consult/Office Visit Notes	___ Received by OHC
____ Pap and HPV Test	___ Received by OHC
____ All Pathology Reports	___ Received by OHC
____ Procedure or Operative Note	___ Received by OHC
____ Imaging & Scans (Pelvic Ultrasound/CT/PET/MRI	___ Received by OHC
____ Recent Mammogram, DEXA, Colonoscopy	___ Received by OHC
____ Labs (Tumor Markers, CA125, CEA, Inhibin B, CBC, Chemistry Panel)	___ Received by OHC

OTHER OR PENDING RESULTS

Please 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 and press 5.
5053 Wooster Road, Cincinnati, Ohio 45226

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