

# 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:

### LUNG

<input type="checkbox"/> Bronchoscopy Report	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Pathology (Bronchial Washings, Staining or Brushing)	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Operative Note and Additional Pathology	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Tumor genetics	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Labs (CBC past and present, Chemistry Panel)	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> CAT Scan/PET Scan/MRI/Other Scans	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> X-rays	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Pulmonary Functions Test (PFTs)	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Consult/Office Visit Notes	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Labs (CEA, NSE, CBC, Chemistry Panel)	<input type="checkbox"/> 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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