OHC Request for Patient Medical Records

OHC
SPECIALISTS IN CANCER AND BLOOD DISORDERS
START HERE.

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:

DVT

____ Factor V, Lupus Anticoagulant, D-Dimer	___ Received by OHC
____ Other Coagulation Labs	___ Received by OHC
____ Dopplers, Ultrasounds	___ Received by OHC
____ EKG	___ Received by OHC
____ CT Chest or Other Scans	___ 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