

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:

DVT

<input type="checkbox"/> Factor V, Lupus Anticoagulant, D-Dimer	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Other Coagulation Labs	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Dopplers, Ultrasounds	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> EKG	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> CT Chest or Other Scans	<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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