

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:

MELANOMA

<input type="checkbox"/> X-rays/Scans	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Operative Report, Sentinel Lymph Node Dissection	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Pathology	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Consult/Office Visit Notes	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Labs (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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