

- **IF THIS IS A CARDIAC, ONCOLOGY or URGENT Request – DO NOT FAX, please call 855.REFER.123 (855.733.3712)**
- Please fax the completed form to 216.448.9738, Attention: Referring Physician Hotline
- Please DO NOT send medical records. If medical records are needed we will request them

**Questions?** Contact the Referring Physicians Hotline, 24 hours a day, 7 days a week, at 855.REFER.123 (855.733.3712). You will receive confirmation once the appointment is scheduled. Thank you for referring to the Cleveland Clinic.

**Appointment Request**

Requested Provider / Specialty: \_\_\_\_\_

Reason for referral (DX or symptoms): \_\_\_\_\_

\_\_\_\_\_

**Patient Information (Please Print)**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ CCF# \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Gender \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insurance Name/Plan: \_\_\_\_\_ Group#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Sub DOB: \_\_\_\_\_

**Referring Physician Information**

Referring Physician's Name (Last, First): \_\_\_\_\_

Contact Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ NPI #: \_\_\_\_\_