Cleveland Clinic

Refer a Patient

- **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 #: _____