

**EMERGENCY DEPARTMENT  
PRIVATE PHYSICIAN REFERRAL SHEET**

ECC FAX# 614-722-6890

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Physician Call Back # \_\_\_\_\_

If different, after hours number please call # \_\_\_\_\_ and the physician on call will handle

Patient's Name: \_\_\_\_\_ Sex:  Male  Female

DOB: \_\_\_\_\_

DOES PATIENT REQUIRE ADMISSION: \_\_\_\_\_

HISTORY AND REASON FOR REFERRAL: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ANY SPECIAL REQUESTS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ANY TESTS/PROCEDURES THAT NEED TO BE COMPLETED: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF ADMITTED DO YOU WISH THEM ON YOUR SERVICE:  Yes  No

IF ADMITTED DO YOU WISH TO BE CALLED:  Yes  No Call Back # \_\_\_\_\_

Route of Transport: \_\_\_\_\_ ETA: \_\_\_\_\_