EMERGENCY DEPARTMENT

PRIVATE PHYSICIAN REFERRAL SHEET

PHYSICIAN CONSULT/TRANSFER CENTER (PCTC)
PCTC FAX # 614-722-2140

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: __________________________