DOERNBECHER CHILDREN'S Hospital

OHSU

TEL: 503-418-4300

FAX: 503-346-8215

Referral Timing

- ○ Routine (NEXT AVAILABLE)
- ○ Semi-urgent (WITHIN 2 WEEKS)
- ○ Urgent* (WITHIN 72 HOURS)
- ○ Immediate* (WITHIN 24 HOURS)

*For urgent appointments, please also call our nurse coordinator

503-418-2843

Primary Obstetric Provider/Clinic

Name:

Practice:

City:

State:

Phone: ( )

Fax: ( )

Cell: ( )

Email:

Preferred Contact Method:

○ Phone ○ Cell ○ Email

OHSU Doernbecher Fetal Care Referral

Thank you for your referral. Please fax the following documents along with this form:

- ○ ALL PRENATAL RECORDS
- ○ DEMOGRAPHIC SHEET

FAX TO: 503-346-8215

Patient Information

Patient name:

Street Address:

City, state:

Zip Code: Date of Birth: / /

Preferred contact phone number: ○ CELL ○ HOME ○ WORK

( ) -

Interpreter needed? ○ NO ○ YES LANGUAGE:

Referring Provider (IF DIFFERENT FROM PRIMARY):

Name: Clinic:

Phone: ( ) Fax: ( )

Insurance Information

Insurance Company: Subscriber DOB: / /

Subscriber Name:

Subscriber ID: Group:

Referral/Authorization # (IF NECESSARY) :

Clinical indication for referral

ICD-10 Code: EDD: / /

Description:

Might this patient need a fetal intervention/procedure/surgery? Yes No