Oregon Health & Science University
Adult Genetics Program Referral

Patient Information

Name:_____DOB:_____/_____/_____
Phone:(h)_____(w)_____
Health Plan:_____Member ID #:_____
□PPO □EPO □POS □Other_____

Is preauthorization required for this consult? □Yes □No
If so, please include authorization/confirmation #_____

Indications for referral

□Personal history of

_____

_____

_____

_____

□Family history of

_____

_____

_____

Referral Information

Referring Provider:_____

Address: _____

Phone:_____ Fax: _____

Permission to contact patient directly: □yes □no

Given this patient's personal and/or family history, I am referring him/her for a consultation/evaluation with a medical geneticist as medically necessary care.

Physician signature:_____

Date:_____

Please fax this referral along with pertinent medical records to (503) 346-0645