



**Department of Neurological Surgery Physician Referral Information Form**

<p><b>Referring adult patient to</b> (choose one please)</p> <p><input type="checkbox"/> Stanley Barnwell, MD, PhD      <input type="checkbox"/> Aclan Dogan, MD  <input type="checkbox"/> Kim J. Burchiel, MD            <input type="checkbox"/> Brian Ragel, MD  <input type="checkbox"/> Johnny B. Delashaw, MD       <input type="checkbox"/> Donald A. Ross, MD  <input type="checkbox"/> Nicholas D. Coppa, MD        <input type="checkbox"/> Other (general referral)</p> <p><b>Referring pediatric patient to</b> (choose one please)</p> <p><input type="checkbox"/> Daniel Guillaume, MD        <input type="checkbox"/> Nathan R. Selden, MD, PhD</p>	<p><b>Type of Evaluation</b> (choose one please)</p> <p><input type="checkbox"/> Consultation  <input type="checkbox"/> Surgical Evaluation  <input type="checkbox"/> 2<sup>nd</sup> Opinion Consult</p> <p><b>DX / ICD-9 CODE(s):</b> _____  <b>Reason for referral:</b> _____</p>
<p><b>Patient Information</b></p> <p>First Name: _____ Last Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>DOB: _____ Gender: <input type="checkbox"/> Male      <input type="checkbox"/> Female  OHSU MR# (if known): _____</p> <p>Home Ph#: _____  Day Ph#: _____  Parent/Guardian (if applicable): _____</p>	<p><b>Interpreter Needed?</b> (choose one please)</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>Language: _____</p>
<p><b>Insurance Information</b></p> <p>Primary Ins. Carrier: _____  ID#: _____  Address: _____  City: _____ State: _____ Zip: _____</p> <p>Ph#: _____  Fax: _____  Email: _____</p>	<p>Secondary Ins: _____  ID#: _____  Address: _____  City: _____ State: _____ Zip: _____</p> <p>Ph#: _____  Fax: _____  Email: _____</p>
<p><b>Authorization Information</b> (if applicable)</p> <p>Auth#: _____</p> <p># of Visits: _____</p> <p>Services Auth'd: <input type="checkbox"/> Consult      <input type="checkbox"/> Surg Option      <input type="checkbox"/> Diagnostic Testing</p> <p>Date Span: _____ to _____</p>	<p><b>Notes</b></p>
<p><b>Referring Provider Information</b></p> <p>Provider Name: _____  Specialty: _____  Tax ID: _____  Address: _____  City: _____ State: _____ Zip: _____</p> <p>Ph#: _____  Fax#: _____  Email: _____</p>	<p><b>Primary Care Provider Information</b>  <input type="checkbox"/> Same as Referring Provider</p> <p>Provider Name: _____  Specialty: _____  Tax ID: _____  Address: _____  City: _____ State: _____ Zip: _____</p> <p>Ph#: _____  Fax#: _____  Email: _____</p>

**\*\*Patients will be advised to HAND CARRY any recent magnetic resonance (MR) images or computed tomography (CT) images OR we can request to have them electronically sent to us from facilities with the ability to do so. Please DO NOT mail images to our office. Please include a complete face sheet, pertinent chart notes & diagnostic reports when you fax this form to us. Our fax number is: (503) 346-6810. Should you have any questions or concerns, please do not hesitate to call us at 503.494.4314**