



OHSU Northwest Pituitary Center Referral Information Form

Please fax this information to (503) 346-6810

Attention Christine H.

Date: ___/___/___

Referring Provider Information (Complete or attach a fax cover sheet)

Referring Doctor: _____ Tax ID: _____
Specialty: _____ Phone: _____
Address: _____ Fax: _____

Patient Information (Complete or attach Demographics)

Patient Name: _____ DOB: ___/___/___ SSN: _____

Patient Address: _____ Home phone: _____ Work phone: _____
Alt. Phone: _____

Male Female

Interpreter Needed: Yes No Language: _____

Please provide the following information:

- Insurance information checkbox
Laboratory, MR imaging reports, and all pertinent chart notes including pituitary workup indicating possible pituitary abnormalities.

Authorization Information (Complete or attach authorization)

Date Span: _____ to _____

Authorization Number: _____

- Endocrinology Consult Two Follow up Visits
Neurological Surgery Consult Surgery Option
Testing: 99215, 99354, J0835

Confidentiality Statement: This message may contain privileged and confidential information and is intended only for the use of the individual or entity to which it is addressed.