



OHSU Northwest Pituitary Center Referral Information Form

Please fax this information to (503) 494-0870

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.