FAX to: 503 494-7161

OHSU Department of Neurological Surgery: Physician Referral Information Form

<table>
<tr><td>
<u>Referring To</u>: (choose one)

☐ Stanley L. Barnwell, M.D., Ph.D.*
☐ Kim J. Burchiel, M.D.
☐ Johnny B. Delashaw, Jr., M.D.
☐ Aclan Dogan, M.D.
☐ Jorgé L. Eller, M.D.
☐ Daniel J. Guillaume, M.D.
☐ Andrew N. Nemecek, M.D.
☐ Edward A. Neuwelt, M.D.
☐ Nathan R. Selden, M.D., Ph.D.
☐ Other (general referral)
</td><td>
<u>Type of Evaluation</u>: (choose one)
☐ Consultation
☐ Surgical
☐ 2nd Opinion/ Consult
Diagnosis/ ICD-9 Code(s):
Reason for referral:
</td></tr>
<tr><td>
<u>Patient Information</u>
First Name Last Name

Address:
City State Zip

Date of Birth: Gender: ☐ Female ☐ Male
OHSU Medical Record #:

Home Phone:
Day Time Phone:
Parent/Guardian (if Applicable):
</td><td>
Interpreter Needed: (choose one)

☐ Yes ☐ No

Language:
</td></tr>
<tr><td>
<u>Insurance Information</u>
Primary Insurance:
ID#:
Address:
City State Zip

Group #:
Date of Injury:
Phone:
Fax:
</td><td>
Secondary Insurance (if applicable):
ID#:
Address:
City State Zip

Group #:
Date of Injury:
Phone:
Fax:
</td></tr>
<tr><td>
<u>Authorization Information</u>
Authorization Number:
Number of Visits:
Authorization for: ☐ Consult ☐ Surgery Option ☐ Diagnostic Testing
Date Span: _______ to ________
</td><td>
<u>Notes</u>
</td></tr>
<tr><td>
<u>Referring Provider Information</u>

Referring Provider:
Specialty:
Tax ID:
Address:
City State Zip

Phone:
Fax:
Email:
</td><td>
<u>Primary Care Provider Information</u>
(☐ Same as Referring Provider)
Primary Care Provider:
Specialty:
Tax ID:
Address:
City State Zip

Phone:
Fax:
Email:
</td></tr>
</table>

We will ask the patient to hand-carry their recent (within six months) MRI, CT and X-Ray films or CD to their appointment. Please **DO NOT** send them to us via postal mail. Include pertinent chart notes and diagnostic reports when you return this form to us by fax at 503-494-7161. If you have any questions, please contact our office at 503-494-4314.

* For Dr. Barnwell fax to 494-7664.