OHSU Northwest Pituitary Center Referral Information Form

Please fax this information to (503) 346-6810
Attention Jenn R.

Date: _____/_____/_____

Patient Information (Complete or attach Demographics)

Patient Name: _____ DOB: / /
Social Security: _____ Home: (_____) _____ - _____
Patient Address: _____Work: (_____) _____ - _____
_____Alt. Phone: (_____) _____ - _____

Interpreter Needed: ___ Yes No Language: _____

☐ Male ☐ Female

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

Referring Doctor: _____ Tax ID: _____
Specialty: _____ Phone: (_____) _____-_____
Address: _____ Fax: (_____) _____-_____
_____

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Please provide the following information:

Patient's current insurance information (*copy of insurance card or insurance & demographics*)

Lab, MRI reports, and the last 2-3 pertinent chart notes that discuss pituitary abnormality &/or workup

Authorization Information (Complete or attach authorization)

Date Span: _____ to _____

Authorization Number & Inclusions (please check below): _____

Endocrinology Consult Two Follow Up Visits Neurosurgery Consult Surgery Option

CST: Low Dose Cortrosyn Stimulation Test
99215
99354
J0835