Department of Dermatology

3303 SW Bond Ave, Mailcode: CH16D
Portland, OR 97239

Medical and Pediatric Appointment Line: 503-418-3376
Medical and Pediatric Referral/Authorization/Records Fax: 503-494-1228

Surgical and Cosmetic Appointment Line: 503-494-6483
Surgical Referral/Authorization/Records Fax: 503-494-0596

Patient Demographics and Referral Form

Patient Demographics

Full Name: ______________________________
Last *First* *M.I.*

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Home Phone: (   ) ______________ Alternate Phone: (   ) ______________

☐ Male

☐ Female Interpreter Needed? ☐ Yes ☐ No If yes, Language: ______________

Social Security Number or Government ID: ______________

Birth Date: ______________ OHSU MRN: ______________

<u>If the patient is a child under the age of 18:</u>

Parent's Name: Mother: ______________ Father: ______________

Guardian's Name: ______________

Insurance Information

Insurance: ______________ Primary Subscriber and DOB: ______________

ID Number: ______________ Group Number: ______________

Referral Information

Referring Provider Name: ______________________________
Last *First* *M.I.*

Primary Phone: (   ) ______________ Fax: (   ) ______________

Dx Code (ICD-9): ______________

Brief Description: ______________________________

____

Authorization Number: ______________ # of visits ______________ Expiration Date: ______________

Referred To:

Referral Status: ☐ Urgent ☐ Routine Chart Notes Included ☐

CHART NOTES REQUIRED FOR ALL CONSULTS