



**Doernbecher  
Children's Hospital**  
*A division of Oregon Health & Science University*

Thank you for referring your patient to  
OHSU Doernbecher Children's Hospital.

**Please indicate the specialty**  
to which you are referring your patient:

- |  |   |
|--|---|
| <input type="checkbox"/> <b>Audiology (and cochlear implant)</b> | <input type="checkbox"/> <b>Neurodevelopment</b>                    |
| <input type="checkbox"/> <b>Autism</b>                           | <input type="checkbox"/> <b>Neurology</b>                           |
| <input type="checkbox"/> <b>ADHD</b>                             | <input type="checkbox"/> <b>Neuropsychology</b>                     |
| <input type="checkbox"/> <b>Cardiac Surgery</b>                  | <input type="checkbox"/> <b>Neurosurgery</b>                        |
| <input type="checkbox"/> <b>Cardiology</b>                       | <input type="checkbox"/> <b>Obesity (Healthy Lifestyles clinic)</b> |
| <input type="checkbox"/> <b>Child Development</b>                | <input type="checkbox"/> <b>Occupational Therapy</b>                |
| <input type="checkbox"/> <b>Cleft Palate - Craniofacial</b>      | <input type="checkbox"/> <b>Ophthalmology</b>                       |
| <input type="checkbox"/> <b>Dermatology</b>                      | <input type="checkbox"/> <b>Orthopaedics</b>                        |
| <input type="checkbox"/> <b>Diabetes</b>                         | <input type="checkbox"/> <b>Otolaryngology (cochlear)</b>           |
| <input type="checkbox"/> <b>Down Syndrome</b>                    | <input type="checkbox"/> <b>Pain Management</b>                     |
| <input type="checkbox"/> <b>Endocrinology</b>                    | <input type="checkbox"/> <b>Physical Therapy</b>                    |
| <input type="checkbox"/> <b>Feeding and Swallowing</b>           | <input type="checkbox"/> <b>Plastic Surgery</b>                     |
| <input type="checkbox"/> <b>Gastroenterology</b>                 | <input type="checkbox"/> <b>Psychiatry</b>                          |
| <input type="checkbox"/> <b>General Pediatrics</b>               | <input type="checkbox"/> <b>Psychology</b>                          |
| <input type="checkbox"/> <b>General Surgery</b>                  | <input type="checkbox"/> <b>Pulmonary</b>                           |
| <input type="checkbox"/> <b>Genetics</b>                         | <input type="checkbox"/> <b>Rett Syndrome</b>                       |
| <input type="checkbox"/> <b>Hematology/ Oncology</b>             | <input type="checkbox"/> <b>Sleep Clinic</b>                        |
| <input type="checkbox"/> <b>Hemophilia</b>                       | <input type="checkbox"/> <b>Special Needs Dental</b>                |
| <input type="checkbox"/> <b>Infectious Disease</b>               | <input type="checkbox"/> <b>Speech and Language</b>                 |
| <input type="checkbox"/> <b>Lactation</b>                        | <input type="checkbox"/> <b>Tone Management</b>                     |
| <input type="checkbox"/> <b>Lipid Clinic</b>                     | <input type="checkbox"/> <b>Urology</b>                             |
| <input type="checkbox"/> <b>Liver Clinic</b>                     | <input type="checkbox"/> <b>Vascular Anomalies</b>                  |
| <input type="checkbox"/> <b>Metabolism</b>                       | <input type="checkbox"/> <b>Voice and Swallowing</b>                |
| <input type="checkbox"/> <b>Nephrology</b>                       |   |
| <input type="checkbox"/> <b>Other:</b> _____                     |   |
| _____  |   |
| _____  |   |

• For **Radiology, Lab** or **Echo** referral, see [www.doernbecher.com/referral](http://www.doernbecher.com/referral)

## Consultation Request to Doernbecher Specialty Pediatric Clinics

Please provide the following so we can quickly schedule an appointment:

- Pertinent medical records  Demographic sheet  Insurance authorization (if required)

**Fax this form and pertinent medical records to:**

**888 346-0645 or 503 346-0645.**

### Patient Information

Patient Name: \_\_\_\_\_  M  F

City, State: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian: \_\_\_\_\_

*(Please check preferred contact phone number.)*

Home \_\_\_\_\_  Cell \_\_\_\_\_  Work \_\_\_\_\_

Interpreter needed?  Yes  No If yes, Language: \_\_\_\_\_

Primary Care Provider (if different from referring): \_\_\_\_\_

**This visit is ... (mark one):**

- Routine:** Within 30 days  **Semi-Urgent:\*** Within 2 weeks

- Urgent:\*** Less than 48 hours *(For urgent appointments, please call us at 503 346-0644 or 1-888-346-0644)*

\* If Urgent or Semi-Urgent, please specify a reason: \_\_\_\_\_

ICD-9 code: \_\_\_\_\_

### Patient's Medical Issue:

Please tell us what specific medical issue to address at this visit:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Referring Provider Information

Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

City, State: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Office Contact: \_\_\_\_\_

### OFFICE USE ONLY

Date Received: \_\_\_\_\_ Received by: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_ Reviewing Provider: \_\_\_\_\_

\_\_\_\_\_

To **call** in your referral:  
**503 346-0644**  
or **1-888-346-0644.**



**OREGON  
HEALTH & SCIENCE  
UNIVERSITY**