OHSU Doernbecher Children's Hospital
700 S.W. Campus Drive
Portland, OR 97239
TEL **503-346-0644**
TOLL FREE **888-346-0644**
FAX **503-346-0645**

Thank you for referring your patient to OHSU Doernbecher Children's Hospital. Please indicate the specialty to which you are referring your patient:

- ◯ Adolescent Health / Eating Disorders
- ◯ Aerodigestive Clinic
- ◯ Audiology
- ◯ Autism
- ◯ Behavioral Pediatrics
- ◯ Cardiac Surgery
- ◯ Cardiology
- ◯ Child Development
- ◯ Cleft Lip / Palate – Craniofacial
- ◯ Cochlear Implant
- ◯ Congenital Brain Abnormalities
- ◯ Dermatology
- ◯ Diabetes
- ◯ Down Syndrome
- ◯ Endocrinology
- ◯ Feeding and Swallowing
- ◯ Gastroenterology / Liver Clinic
- ◯ General Pediatrics
- ◯ General Surgery
- ◯ Genetics
- ◯ Hematology / Oncology
- ◯ Hemophilia, Bleeding and Thrombosis
- ◯ Infectious Disease
- ◯ Lactation
- ◯ Lipid Clinic
- ◯ Metabolism
- ◯ Nephrology
- ◯ Neurodevelopment
- ◯ Neurology
- ◯ Neuropsychology
- ◯ Neurosurgery
- ◯ Nutrition
- ◯ Obesity (Healthy Lifestyles clinic)
- ◯ Occupational Therapy
- ◯ Ophthalmology
- ◯ Orthopaedics
- ◯ Otolaryngology / ENT
- ◯ Physical Therapy
- ◯ Plastic Surgery
- ◯ Psychiatry
- ◯ Psychology
- ◯ Pulmonary
- ◯ Rett Syndrome
- ◯ Scoliosis and Pediatric Spinal Deformity
- ◯ Sex Development Program
- ◯ Sleep Clinic
- ◯ Special Needs Dental
- ◯ Speech and Language
- ◯ Spina Bifida
- ◯ Urology
- ◯ Vascular Anomalies
- ◯ Voice and Swallowing
- ◯ Other _____

For Radiology, Lab or Echo referral, see **www.doernbecher.com/referral**.

OHSU Doernbecher Specialty Clinics Referral Form

Please provide the following so we can schedule an appointment:
◯ PERTINENT MEDICAL RECORDS ◯ DEMOGRAPHIC SHEET
◯ INSURANCE AUTHORIZATION (IF REQUIRED)

FAX THIS FORM AND PERTINENT MEDICAL RECORDS TO **503-346-0645** OR **888-346-0645**

Patient information

Patient name: ◯ M ◯ F

Street address:

City, state: Date of birth:

Parent/guardian:

Please check preferred contact phone number:
◯ HOME ◯ CELL ◯ WORK

Interpreter needed? ◯ YES ◯ NO LANGUAGE:

Insurance Co.: Member #:

Auth #: Notes:

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

* If urgent or semi-urgent, please specify a reason:

Patient's medical issue

ICD-10 code:

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:

FOR MORE REFERRAL FORMS, PLEASE GO TO **WWW.DOERNBECHER.COM/REFERRAL**. QUESTIONS ABOUT THIS REFERRAL? CALL US AT **503 346-0644** OR **888 346-0644**.

OHSU DOERNBECHER CHILDREN'S *Hospital*

FOR OFFICE USE ONLY
Date received: _____ Received by: _____ Date reviewed: _____ Reviewing provider: _____