



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"/> Audiology | <input type="checkbox"/> Nephrology |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Neurodevelopment |
| <input type="checkbox"/> Cardiac Surgery | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Neuropsychology |
| <input type="checkbox"/> Child Development | <input type="checkbox"/> Neurosurgery |
| <input type="checkbox"/> Cleft Palate - Craniofacial | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Orthopedics |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Otolaryngology |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Feeding and Swallowing | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> General Pediatrics | <input type="checkbox"/> Pulmonary |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Special Needs Dental |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> Speech and Language |
| <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Tone Management |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Vascular Anomalies |
| <input type="checkbox"/> Lactation | <input type="checkbox"/> Voice and Swallowing |
| <input type="checkbox"/> Lipid Clinic | |
| <input type="checkbox"/> Metabolism | |

Other: _____

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

Please fax this form and pertinent medical records (i.e. growth charts, clinic notes, lab results or imaging reports) to **888 346-0645** or **503 346-0645**

Consultation Request to Medical Specialties

Please provide the following information and pertinent medical records so we can quickly schedule your patient.

Patient Information

Patient Name: _____ M F

City, State: _____ Date of Birth: ____/____/____

Parent/Guardian Name(s): _____

(Please check preferred contact phone number:)

Home _____ Cell _____ Work _____

Interpreter needed? Yes No If yes, Language: _____

Primary Care Provider (if different from referring): _____

Insurance Co.: _____ Member No.: _____

Auth # _____ Notes: _____

This visit is ... (mark one):

Routine: Next available appointment **Semi-Urgent:*** Two weeks or less

Emergent:* One day to one week *(In addition to completing this form, please call 503 346-0644 or 1-888-346-0644)*

* If Emergent or Semi-Urgent, please specify a reason: _____

Patient's Medical Issue:

ICD-9 Code: _____

Description: _____

Pertinent past medical history and lab results: _____

Are you expecting that any procedure or diagnostic studies will be needed during this visit? If so, please list:

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