Physician referral form

Thank you for choosing the Comprehensive Pain Center at OHSU. Our physicians provide consultative recommendations and treatment evaluations. If medical management or ongoing treatment is recommended, we will work collaboratively with you and any other treating providers.

In order for your patient to obtain the most benefit from his/her initial visit, please provide the following documentation:

1. Completed referral form
2. Progress notes
3. Imaging reports (X-rays, MRIs, CTs—within the last 2 years)
4. Procedure notes
5. Insurance verification/authorization

Once we receive the referral, we will complete a medical review, benefit check, and will call the patient to schedule if the referral is appropriate for our clinic.

Please fax the completed referral form and documentation to 503-346-6961. If there are questions, please contact us at 503-494-7246.
☐ This is an urgent referral

**Patient demographics:**

Name: ____________________________________________

Address: _________________________________________

City: ___________ State: _______ Zip: ___________

Home: (_____) _________________________________

Work: (_____) ___________ Cell: (_____) ___________

DOB: ______________________ SSN: __________________

**Diagnosis/ICD-10 code(s):**

1. _____________________________________________

2. _____________________________________________

3. _____________________________________________

**Reason for referral** (check box):

☐ Consultation

☐ Specific treatment requested: ______________________

Specific questions to be addressed: __________________

**Referring provider** *(Patients are required to be under the care of a PCP):*

**Referring provider** .......................... **PCP**

Name: ___________________ Name: ___________________

Phone: ___________________ Phone: ___________________

Fax: ___________________ Fax: ___________________

**Insurance information:**

**Primary Insurance**

Policyholder: ________________________________

Policy ID #: ___________ Group #: _____________

Phone: ___________________ Authorization #: __________

**Secondary insurance**

Policyholder: ________________________________

Policy ID #: ___________ Group #: _____________

Phone: ___________________ Authorization #: __________