OHSU COMPREHENSIVE PAIN CENTER

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**.

OHSU Comprehensive Pain Center
Center for Health & Healing
3303 S.W. Bond Ave., 15th Floor
Portland, OR 97239

Tel: 503-494-7246
Fax: 503-346-6961

OHSU

☐ 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 #: _____

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