OHSU
3181 S.W. Sam Jackson Park Road
Portland, OR 97239-3098
TEL **503-494-4567**
TOLL FREE **800-245-6478**
FAX **503-346-6854**

Thank you for referring your patient to OHSU. Please indicate the specialty to which you are referring your patient:

- Allergy and Immunology
- Arthritis and Rheumatology
- Bariatric Surgery
- Cardiology
- Cardiothoracic Surgery
- Dermatology
- Digestive Health (GI, HEPATOLOGY, GI SURGERY)
- Endocrinology
- Family Medicine
- General Surgery
- Genetic Medicine
- Hematology & Medical Oncology
  - Marquam Hill
  - Beaverton
  - Gresham
  - N.W. Portland
  - East Portland
  - Tualatin
- Infectious Disease
- Internal Medicine
- Interventional Radiology
- Nephrology and Hypertension
- Neurology
- Neurosurgery
- OB/GYN
- Ophthalmology
- Oral Surgery and Maxillofacial Surgery
- Orthopaedics
- Otolaryngology
- Pain Center
- Pediatrics
- Perinatology
- Plastic and Reconstructive Surgery
- Psychiatry
- Pulmonary Care
- Radiation Medicine
- Rehabilitation Services (Including TBI)
- Sleep and Mood Disorders
- Spine Center
- Sports Medicine
- Surgical Oncology
- Transplant
- Trauma
- Urologic Surgery
- Vascular Surgery
- Other ______________________

Specific physician ______________

For additional referral or radiology, ~~lab or echo physician~~ order forms, please visit **www.ohsu.edu/provider**.

HCM 21477963 9/18

OHSU Referral Form

Please provide the following so we can schedule an appointment:

PERTINENT MEDICAL RECORDS DEMOGRAPHIC SHEET
INSURANCE AUTHORIZATION (IF REQUIRED)

FAX WITH PERTINENT MEDICAL RECORDS TO: **503-346-6854**

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:

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 **503-494-4567** or **800-245-6478**

I am requesting: CONSULT ONLY ONGOING CARE REFERRAL REQUESTED BY MY PATIENT

Patient's medical issue

ICD-10 code:

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

Information check off list PLEASE ATTACH (WHERE APPLICABLE):

PROGRESS NOTES PREVIOUS WORK UP FOR THESE SYMPTOMS
LABS PATHOLOGY
IMAGING, X-RAYS, MRI, CT SCANS OB/GYN
MEDICATION LIST, ALLERGIES OTHER: ______________

Referring provider information

Name: Clinic:

City, state: Phone no.:

Fax: E-mail:

Office contact: