

**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
- Casey Eye Institute
- Specialty: \_\_\_\_\_
- 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
- Sleep and Mood Disorders
- Spine Center
- Sports Medicine
- Surgical Oncology
- Transplant
- Trauma
- Urologic Surgery
- Vascular Surgery
- Other \_\_\_\_\_

Specific physician \_\_\_\_\_

For Radiology, Lab or Echo referral, download Physician Order Form - Imaging Services at [www.ohsuhealth.com/provider](http://www.ohsuhealth.com/provider).

**OHSU 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 **503-346-6854**

**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, MRIS, CT SCANS
- OB/GYN
- MEDICATION LIST, ALLERGIES
- OTHER: \_\_\_\_\_

**Referring provider information**

Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

City, state: \_\_\_\_\_ Phone no.: \_\_\_\_\_

Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Office contact: \_\_\_\_\_

For more referral forms, please go to [www.ohsuhealth.com/provider](http://www.ohsuhealth.com/provider).

QUESTIONS ABOUT THIS REFERRAL? CALL US AT 503-494-4567 OR 800-245-6478.

