Consultation Request to OHSU/IVC Filter Clinic

Fill out	Attach	Fax	Call
Please complete the following so we can schedule an appointment	Attach pertinent medical record & demographic sheet	Please fax this form to (503) 494-7664. Include insurance authorization(if required)	Please call in your referral to (503) 494-7117

OREGON HEALTH & SCIENCE UNIVERSITY

Patient Information

Name: ☐ M ☐ F

Date of Birth: _____/_____/_____

(Please check preferred contact phone numbers)

☐ Home Phone: ☐ Cell: ☐ Work:

Address/City/State/Zip:

Parent/Guardian Names(s) (if applicable):

Interpreter needed? ☐ Yes ☐ No If yes, 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

I am requesting: ☐ IVC Filter Placement ☐ IVC Filter Retrieval

Patient's Medical Issue

ICD-9 code:

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

Information Check List: Please attach (where applicable)

☐ Progress Notes ☐ Medication List, Allergies

☐ Labs ☐ IVC Filter procedure notes and images

☐ Imaging, X-rays, MRIs, CT Scans

Referring Provider Information

Name: Clinic:

City, State Phone No:

Fax: E-mail:

Office contact:

To call in your referral: (503) 494-7117

OHSU
IVC Filter Clinic