

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
- Endocrine Surgery
- Family Medicine
- General Surgery
- Genetic Medicine
- Hematology & Medical Oncology
 - Marquam Hill
 - Beaverton
 - Gresham
 - N.W. Portland
 - East Portland
 - Tualatin
- Hemophilia Center
- 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
- Wound Care/Hyperbaric

Other _____

Specific physician _____

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

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 NEXT AVAILABLE **Emergent*** LESS THAN 48 HOURS

* For emergent 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: _____

