TEL **503-494-4567**
TOLL FREE **800-245-6478**

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 and 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
  - ◯ Fetal Therapy
  - ◯ Perinatology
- ◯ Ophthalmology
- ◯ Oral Surgery and Maxillofacial Surgery
- ◯ Orthopaedics
- ◯ Otolaryngology
- ◯ Pain Center
- ◯ Pediatrics
- ◯ Plastic and Reconstructive Surgery
- ◯ Psychiatry
- ◯ Pulmonary Care
- ◯ Radiation Medicine
- ◯ Rehabilitation Services (Including TBI)
- ◯ Sleep and Mood Disorders
- ◯ Spine Center
- ◯ Sports Medicine
- ◯ Surgical Oncology

- ◯ Transplant (TYPE) _____
- ◯ Trauma
- ◯ Urologic Surgery
- ◯ Vascular Surgery
- ◯ Wound Care/Hyperbaric

- ◯ Other _____

- ◯ Specific physician _____

Additional referral, radiology, lab or echo physician order forms available at **www.ohsu.edu/provider**.

OHSU Referral Form

Thank you for your referral. Please fax the following documents along with this form:

◯ PERTINENT MEDICAL RECORDS ◯ DEMOGRAPHIC SHEET
◯ INSURANCE AUTHORIZATION (IF REQUIRED)

FAX TO: 503-346-6854

Patient information

Patient name: ◯ M ◯ F

Street address:

City, state: Zip code:

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 ◯ **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.:

E-mail: Fax:

Office contact:

OHSU