Deliver to: OHSU Telemedicine Network

FAX: 503-418-3746

Date: ____________________  Total pages (including cover): ________

From: __________________________

Included with fax:

___ Signed OHSU Terms and Conditions of Service

___ Signed OHSU Telemedicine Consent Form

___ Patient’s face sheet
   - Face sheet is only required if patient is not transferred to OHSU

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