

Please complete all fields and email to ohsuhshrs@ohsu.edu

Incomplete requests will not be processed.

Please complete as fillable PDF – handwritten requests will not be accepted.

Any requests received after 4pm will be reviewed the following business day.

Member and Provider Information

Member Name: _____ Date: _____

Member ID: _____ DOB: _____

Requestor Name: _____ Facility Name: _____

Requestor Phone: _____ Admit Date(s): _____

Admit Diagnoses: _____

Referral Information

Insurance Coverage:

HSO/OHSU Health Services

Request:

Initial Request (30 days) Extension Request, additional days requested (30-day max): _____

OHSU Health Services RCP requirements:

Member agrees to engage in medical care

Member agrees to engage with RCP and Health Services Care Manager during stay

RCP has accepted member: Yes No **Anticipated admission date to RCP:** _____

Please note that motel bridges are not covered by Flexible Services funding prior to RCP admission.

Anticipated goals and objective of stay:**Indicate care that is been ordered for member:**

Wound care Occupational Therapy

Physical Therapy

OP Infusion

Home Health (list provider): _____

Other: _____

Please list any additional referrals or services planned for post-discharge care: