

Please complete all fields and email to [ohsuhshrs@ohsu.edu](mailto: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:**