

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:

Length of stay requested (30-day max): _____

OHSU Health Services Requirements:

Member agrees to engage in medical care

Member agrees to engage with Health Services Care Manager during stay

Requestor has reached out to Sapphire Gateway staff to ensure room is available: Yes No

Anticipated check-in date to Sapphire Gateway: _____

Contact – Admissions Coordinator Ph: 971-292-8436 Email: kkehl@sapphirehealthservices.com

Anticipated goals and objective of stay:**Indicate care that has 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:

Does the member have a caregiver that needs to go to Sapphire Gateway for support with the members' medical needs? Yes No If yes, caregivers name: _____

Does the member have a support animal? Yes No If yes, type of animal: _____