



Hospitals & Clinics

Mail code: OP02
3181 S.W. Sam Jackson Park
Portland, OR 97239-3098
tel 503 494-8617
fax 503 494-6170

OHSU ADULT PSYCHIATRY CLINIC

REFERRAL FORM

Thank you for choosing Adult Outpatient Psychiatry at OHSU. We offer a variety of services including; consultative services to Patients and their Primary Care Team, medication management, psychotherapy and other ongoing care treatments. In order for your patient to obtain the most benefit from his/her appointment, please provide the following documentation:

- 1) Completed referral form**
- 2) Progress Notes**
- 3) Relevant labs or imaging report.**

Please be aware that many insurance carriers and county mental health organizations limit the panel of providers authorized to treat their members. After we receive referral information, we will review clinical and insurance information and offer an intake appointment if appropriate.

Please fax the completed referral form and documentation to 503-494-6170.

If there are any questions please contact 503-494-6176 to reach our intake coordinator.

Please complete ALL sections and fax with chart notes to 503 494-6170 (existing documents that cover this information are also acceptable)

1. PCP Information (required for all consultation requests)

Name:

Referral coordinator / contact person:

Phone:

Fax:

2. Referring Provider (if not PCP)

Name:

Specialty:

Phone:

Fax:

3. Patient Demographics

Patient's Name:

Date of Birth:

Address:

City, State Zip code:

Home Phone:

Work:

Cell:

Please circle best number if known

4. Insurance information

Company:

Policy Holders Name:

Policy ID#:

Group #

Insurance Phone #:

Reason for Referral:

Medical Problem List:

None

1.

2.

3.

4.

5.

6.

Current Medication List (all):

None

1.

2.

3.

4.

5.

6.

ADVERSE REACTIONS:

HISTORY OF SUICIDAL OR HOMICIDAL IDEATION OR CURRENT CONCERNS?

Current Diagnosis:

1.

2.

3.

4.

5.

6.

Other Comments:

