

REFERRAL FORM

Oregon Surgical Specialists Surgeons:

William Faught, MD | David Traul, MD | Mark Eaton, MD | Juan Castillo, MD
 Mitchell Plummer, MD | Patrick Phelan, MD | Julianne Allen, MD



oregon
 surgical
 SPECIALISTS

Thank you for choosing to refer your patient to Oregon Surgical Specialists. To start the referral process, please fax this form to our **Medical Records Department at (541) 245-4808**. **If your patient's insurance requires an authorization, please also send that authorization with your referral.**

FAX INFORMATION	
Date:	# of pages:
To: OSS Medical Records	From:
Fax: (541) 245-4808	Your phone #:
	Your fax #:
PATIENT INFORMATION	
Name of patient:	
DOB:	
Home phone:	Work <input type="radio"/> Mobile <input type="radio"/> :
Address:	
City/St: Zip:	Insurance ID #:
Insurance:	Authorization initiated: <input type="radio"/> Yes <input type="radio"/> No
CONSULTATION REQUEST	
Diagnosis/ICD-10:	URGENT: (circle one) YES NO
Reason for consultation:	

- Please include all chart notes, place, date and time of any scans or studies.
- Include patient's insurance card (both sides) **and authorization**, if required.

REFERRING PHYSICIAN INFORMATION	
Referring MD:	
Phone:	Fax:
Contact name:	Phone:

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation.

We look forward to caring for your patient.

Signature: _____ Date: _____

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.