



## Referral Form

3 easy ways to refer a New Patient:	To Refer a Current Shriners Patient:
1. Complete this form and fax to: 503.221.3483	1. Parent/Guardian call Scheduling: 503.221.3422
2. Call New Patient Dept.: 503.221.3422	2. Fax <i>pertinent</i> chart notes & demographic page to Shriners Medical Records Dept: 503.221.3713
3. Email Referral form to: newpatient@shrinenet.org	

PATIENT INFORMATION:			
Last Name:		First Name:	
Gender	Date of Birth	Parent/Guardian Phone Number	Alternate Phone Number
<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /		
Reason for Referral: <i>(Please be specific)</i>			

PARENT / LEGAL GUARDIAN INFORMATION:			
Last Name:		First Name:	
Street Address:			
City:		State:	Zip:
Preferred Language <i>(if other than English):</i>		Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

REFERRING PROVIDER INFORMATION:			
Provider Name:		<input type="checkbox"/> MD <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/> RN <input type="checkbox"/> DO <input type="checkbox"/> PT <input type="checkbox"/> Other	
Contact Name:	Phone:	Email:	
Street Address:			
City:		State:	Zip:
Office Phone:		Fax:	

Insurance Information:	
Insurance Name:	Plan Name:
Subscriber/Member ID:	Group Number:
Subscriber/Member Name:	Subscriber DOB:

*For more information and a list of conditions treated, please visit: [www.shrinershospitalsforchildren.org/portland](http://www.shrinershospitalsforchildren.org/portland)*