Provider Referral Form
Mt Hood Women's Health, P.C.
Phone (503) 491-9444 Fax (503) 661-3430

Date: _____

Referring Provider_____

Provider Phone # _____

Provider Fax # _____

Patient Name: _____ DOB: _____

Patient Phone # _____

Patient address: _____

_____

Patient Diagnosis: _____

Additional information: _____

Is this appointment urgent Yes No

Please fax all pertinent chart notes, labs, and imaging reports.
The provider on call will review records within 24-48 hours of received fax.
Our office will contact the patient to schedule an appointment.
We will notify your office if we are unable to reach the patient and/or the patient does not keep her scheduled appointment.

Please include the following or a copy of patient's current insurance card:

Primary Insurance:_____ phone #_____

Subscriber name: _____

Policy/Group # _____

The providers and staff at Mt Hood Women's health appreciate your referrals.