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Poly Chen, MD; Andrew Oh, MD
Don Winder, PA-C; Jeremy Waldie, PA-C; Nash Keene, PA-C

Patient Referral Form

If you have your own referral form, that includes the requested information below, please feel free to use it. After receipt of your referral we will contact your patient. Additional information is attached to the back of this form.

Date: _____ / _____ / _____

Referring Provider / Specialty: _____

Referring Provider Phone: (____) _____ Fax: (_____) _____

Primary Care Provider: _____

Patient Name: _____ DOB: _____ /_____ / _____

Address: _____

Patient Phone (s): (____) _____ (_____) _____

Reason: _____

_____

Diagnosis: _____

Primary Insurance: _____ID:_____Group: _____

AUTH/REF# _____ **Number of visits** _____

Valid Dates: _____

Other Requests: _____

Please include the following information with this referral if possible:

Imaging, MRI, CT, plain films
Medication lists
Progress notes
Demographics

Please contact our Referral Department with any questions or concerns at (503) 371-1010.

Thank you for your referral.