GOOD SHEPHERD HEALTH CARE SYSTEM
610 NW 11th ST, Hermiston, OR 97838

# Referral Request Form

Attn: Treatment Center, Unit C
Phone: 541-667-3680 Fax: 541-303-8875
Return via email to: txreferrals@gshealth.org

# External Outpatient Referral Form

**All information on this form *_REQUIRED_ for patient to be scheduled**

## Referring Provider

Referring MD/NP/PA: _____ _____ _____ _____
Last Name First Name Telephone Fax

## Reason for Referral

Reason for Visit:_____

*J-Code: J | | | | |
Letter Number Letters or Numbers

*Diagnosis: _____

*ICD10 Code : | | | . | | | | |
(min 3 & max 7 characters)

Please fax all relevant clinical documents (i.e. clinic notes, ***history and physical**, ***orders,** ***J-Code if a medication is order,** progress notes, medication history, height and weight, labs, diagnostic reports and copy of insurance card.

***Please remember to fax authorization.**

## Required Patient Information

◯ Female ◯ Male Interpreter required? ◯ Yes ◯ No If yes, what language? _____

_____
Last Name First Name Middle Name

Date of Birth: | | / | | / | | | | Age: _____
Patient's Address:_____ City/State/Zip: _____
Patient's Phone: _____ Alternate Phone: _____
Home/Cell/Work Home/Cell/Work
Guardian Name: _____ Guardian Relationship: _____

## Insurance Information

***PLEASE INCLUDE A LEGIBLE COPY OF THE INSURANCE CARD (BOTH SIDES), AND AUTHORIZATION IF REQUIRED***

Guarantor DOB: | | / | | / | | | |

Authorization Required: ◯ Yes ◯ No # Visits Authorized:_____ Auth#:_____

Authorization Expiration Date: | | / | | / | | | |

## Physician Orders

◯ Signed orders with diagnosis code attached, form complete

**OR**

◯ *Follow orders below :

Referring provider signature:_____Date:_____
*Signature required only if written orders are provided above