PNW
SPINE AND JOINT
PHYSICIANS

Referral Form

1836 NE 7th Avenue STE 206
Portland, Oregon 97212
Phone: 971-383-1960
Fax: 866-329-9002

* Denotes a required field

*Patient Name: _____ *DOB:_____

*Phone Number:_____ Email:_____

*Referring Provider: _____

*Referring Provider Phone Number:_____

*Referring Provider Fax Number:_____

*Reason for Consult (Please include diagnoses if known and/or body areas of concern):

_____

_____

Please note we are **NOT** in network with most commercial insurance plans, and do no accept Medicare or State of Oregon sponsored insurance. We do accept all motor vehicle insurances and cash pay patients. Please check our website for the most up to date insurance information.

Motor Vehicle Collisions: This section is **required** for all MVC related referrals:

*Date of Loss:_____ *Auto Insurance:_____

*Claim Number: _____

*Attorney:_____

If the patient has more than one open MVC claim, provide all of the above information for both.

Please include all of the following for a complete referral:

☑ Reports for all relevant MRIs, CT Scans, EMGs ☑ Demographic Sheet

☑ Initial new patient note and most recent progress note

☑ Completed Referral Form (can use this form or your own form as long as all info is provided)

A fillable PDF version of this form is available on our website (www.pnwspineandjoint.com)

Please call us with any questions. We appreciate your referral!