## Randall's Children's Diabetes and Endocrine Center Legacy Emanuel Children's Hospital 501 N. Graham, Ste 375 Portland, OR 97227

Phone (503) 413-1600 Fax (503) 413-1915

PATIENT INFORMATION:

Is the family aware of the reason for referral?

## Fields with a star (\*) are required \*Patient Name: \*DOB: \*Parent/Guardian: \*Contact Phone: \*Residential Address: \*Insurance Information: REFERRING PROVIDER INFORMATION: \*Referring Provider Name: \*Referring Provider Phone: \*Referring Provider Fax: **REASON FOR REFERRAL:** PERTINENT INFORMATION: (include symptoms, physical exam, labs, imaging) \*Please fax us all relevant test results and/or office notes with this form to the fax number above (e.g. demographics sheet, last physical exam, growth charts, lab and other diagnostic reports. Please see attached page for items needed for referral diagnosis

\_\_\_ Yes \_\_\_ No