Randall Children's Neurosurgery

Physician Referral Form

RANDALL CHILDREN'S Specialty Care

A service of Legacy Medical Group

Clinic hours: Monday–Friday, 8 a.m.–5 p.m.
Phone: **503-413-3690** • Fax: **503-413-3660**

After hours, call **Legacy One Call Consult & Transfer: 1-800-500-9111** to speak to the on-call neurosurgeon.

Legacy Emanuel Medical Center
Medical Office Building 2
501 N. Graham St., Suite 330B
Portland, OR 97227

Patient information

Last name _____ Legal first name _____ M.I. ____

Address _____

City _____ State _____ Zip _____

Sex: ○ Male ○ Female Date of birth (mm/dd/yyyy)_____

Parent/guardian_____

Primary phone (home/cell/work) _____ Secondary phone (home/cell/work) _____

Interpreter needed? ○ Yes ○ No If yes, language _____

Reason for referral (check boxes)

☐ Arachnoid cyst
☐ Brain or spinal cord tumor
☐ Cranial or spinal malformation
☐ Craniosynostosis
☐ Hydrocephalus
☐ Head or spine injury
☐ Spasticity
☐ Spina bifida
☐ Tethered spinal cord
☐ Vagus nerve stimulation
☐ Vascular malformation

☐ Other_____

Please provide details of the patient's medical issue

_____

Has imaging been done for this diagnosis? ○ Yes ○ No Date_____

Facility where imaging was done _____

Preferred Randall Children's provider (optional):_____

Insurance information

Insurance name_____

Group/I.D. number _____ Authorization number _____

Referring provider information

Name_____ Clinic _____

City _____ State_____ Phone_____

Fax_____ Email _____

Office contact _____

Primary care provider (if different from referring) _____