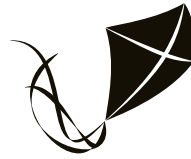


Randall Children's Neurosurgery



**RANDALL CHILDREN'S
Specialty Care**

A service of Legacy Medical Group

Physician Referral Form

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)

- | | | |
|---|---|--|
| <input type="checkbox"/> Arachnoid cyst | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Tethered spinal cord |
| <input type="checkbox"/> Brain or spinal cord tumor | <input type="checkbox"/> Head or spine injury | <input type="checkbox"/> Vagus nerve stimulation |
| <input type="checkbox"/> Cranial or spinal malformation | <input type="checkbox"/> Spasticity | <input type="checkbox"/> Vascular malformation |
| <input type="checkbox"/> Craniosynostosis | <input type="checkbox"/> Spina bifida | |
| <input type="checkbox"/> 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) _____