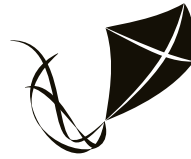


# Randall Children's Orthopedics



**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: **503-413-4488**

Fax: **503-413-1812**

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

Legacy Emanuel Medical Center  
Legacy Orthopedic Building  
450 N. Graham St.  
Portland, OR 97227

Legacy Medical Group–Cornell  
Cornell Medical Plaza  
1960 N.W. 167th Place, Suite 200  
Beaverton, OR 97006

### 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)

Fracture

Scoliosis

Hip Dysplasia

Congenital hand deformity

Club foot

Sports-related injury

Other \_\_\_\_\_

Please provide details of the patient's medical issue

Have X-rays been taken for this diagnosis?  Yes  No Date \_\_\_\_\_

Facility where X-rays were taken \_\_\_\_\_

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) \_\_\_\_\_