



## REFERRAL FORM

Oregon Surgical Specialists Surgeons:  
David Street, MD | William Faught, MD | David Traul, MD | Mark Eaton, MD  
Juan Castillo, MD | Nancy O'Neal, MD

Thank you for choosing to refer your patient to Oregon Surgical Specialists.  
To start the referral process, please fax this form to our **Scheduling Department**  
at **(541) 282-6681**.

*If you require additional assistance, please call our scheduling department at (541) 282-6680.*

FAX INFORMATION	
Date:	# of pgs:
To: OSS Scheduling Department	From:
Fax: (541) 282-6681	Your phone #:
	Your fax #:
PATIENT INFORMATION	
Name of patient:	
DOB:	SS#:
Home phone:	Work <input type="checkbox"/> / cell phone <input type="checkbox"/>
Address:	
City/St:	Zip:
Insurance:	Referral initiated: Yes <input type="checkbox"/> No <input type="checkbox"/>
CONSULTATION REQUEST	
Diagnosis/ICD-9:	
Reason for consultation:	

- Please include all chart notes, place, date and time of any scans or studies.
- Include patient's insurance card (both sides) and HMO authorization if required.

REFERRING PHYSICIAN INFORMATION	
Referring MD:	
Phone:	Fax:
Contact name:	Phone:

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation.

**We look forward to collaborating with you on your patient's treatment plan.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF CONFIDENTIALITY:** This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.