OHSUHealth
Hillsboro Medical Center

Hillsboro Medical Center Cardiovascular Clinic Referral Form

Fax to: 503-346-8449

Patient Information

Patient Name:_____ Preferred name:_____ □ M □ F □ Other

Date of Birth:_____ Phone number:_____

Insurance Carrier & ID# : _____

Street Address:_____

Interpreter needed? _____ Language:_____

Please indicate urgency: □ Urgent (within 48 hours) □ Semi-urgent (within 2 weeks) □ Routine

*Urgent referrals will be reviewed by the providers.

Reason for Visit

ICD 10 code(s): _____

Brief history: _____

_____

_____

Please send along the following information, if you have it:

Within the last year	Within the last 3-5 years	Completed any time
□ ECGs	□ ECHOs	□ Angio/Cardiac Caths
□ Zio Monitors	□ Chest CTs	□ Stress Tests
□ Labs (lipids, A1C, CMP, CBC, TSH)		

Referring provider information

Name: _____ Clinic: _____

Address: _____

Phone: _____

Fax: _____

Office contact: _____