

We do not require a specific form to be completed when referring to our clinics for services. We do, however, need specific information from you in order to move forward with completing the intake process and scheduling an appointment. This form is for your convenience.

Please fax completed forms to the number listed below.

If preferred, most EMR programs will generate a referral form report that includes details we need for a referral. Please review the report before sending to ensure it includes the information requested below, and then fax to the number at the bottom of the page.

Today's Date:

Provider Information	
Referring Provider:	Phone:
Clinic/Facility Name:	Fax:
Reason for Referral	
<input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Mental Health Therapy <input type="checkbox"/> Medical Program <input type="checkbox"/> _____	Please list specific medical issues/concerns/additional instructions:
Client Information	
Client Name:	Date of Birth:
Parent/Guardian:	Client Phone:
Client Insurance:	
Client Diagnosis:	ICD-10 Code <i>(required if referring for OT, PT, & Speech only)</i> :
<i>If we have any questions or need additional information from you Yvonne, our Insurance Specialist, will contact your office directly so we can move forward with scheduling the initial appointment in a timely manner.</i>	

Please FAX this form to our Canby Clinic—Attn: Yvonne at 503-266-8632

Once we receive your referral, we will contact the client or parent/guardian to complete intake process.

THIS FAX MAY CONTAIN PRIVILEGED OR CONFIDENTIAL INFORMATION PROTECTED BY LAW. ANY UNAUTHORIZED DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS PROHIBITED. IF YOU HAVE RECEIVED THIS FAX IN ERROR, PLEASE DESTROY THE ATTACHED DOCUMENT(S) AND NOTIFY US IMMEDIATELY BY TELEPHONE.

~If there is a problem with transmission please call (503) 263-8903.