**Oregon Psychiatric Partners L.L.P and Dr. Franc Strgar, MD. PC**
**3203 Willamette Street Eugene, OR 97405**
**Phone (541) 726-9912**
**Fax (541) 744-4443**

## REFERRAL FORM

**Please complete the form below and fax to 541-744-4443.**

To expedite the process you may include the most recent progress note or other information you feel is helpful to the receiving provider. All information will be reviewed prior to accepting new patients and scheduling appointments.

Thank you

**DATE:** ______________

**REFERRING PROVIDER:** ______________________________________________

**PROVIDER PHONE:** ______________________ **PROVIDER FAX:** ___________________________

**PROVIDER ADDRESS:** ______________________________________________

**REFFERING TO:** _____ **FIRST AVAILABLE PROVIDER**

_____ **SPECIFIC PROVIDER NAME:** ____________________________

**REASON FOR REFERRAL:** ______________________________________________

______________________________________________________________

**CURRENT DIAGNOSES, IF APPLICABLE:** ______________________________________

**PATIENT NAME:** ______________________________________________

LAST FIRST MI

**DOB:** ____________________ **FEMALE/MALE** **MARITAL STATUS:** S M SE D

**PREFERRED PH #**________________ HOME CELL OTHER

**MAILING ADDRESS:**______________________________________________

**PLEASE CHECK HERE IF PATIENT IS NOT COVERED UNDER A MEDICAL INSURANCE PLAN** ☐

**DOES PATIENT HAVE MEDICARE:** ☐ **YES** ☐ **NO** **If Yes, Please list Medicare ID#:** _________________

**PRIMARY INSURANCE NAME:** ______________________________ **PHONE:** _________________

**MEMBER ID:** ____________________________________ **GROUP:** ______________________

**SUBSCRIBER'S NAME:** _________________________________ **DOB:** _______________________

**SECONDARY INSURANCE NAME:** ______________________________ **PHONE:** _______________

**MEMBER ID:** ____________________________________ **GROUP:** ____________________

**SUBSCRIBER'S NAME:** _________________________________ **DOB:** ________________________

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