bmc Total Care™
Bend Memorial Clinic P.C.

Referral Request Form

Thank you for referring your patient to Bend Memorial Clinic.

FAX this form to (541) 706-6474
Please attach any pertinent medical records

Referral type:

☐ Consult ☐ Procedure: _____

☐ Lab ☐ Other: _____

Please mark the specialty or specialties you are referring your patient to:

☐ Allergy
☐ Bariatric Surgery
☐ Cardiology
☐ COAG
☐ Dermatology
☐ Endocrinology
☐ Family Practice
☐ Gastroenterology
☐ Hyperbarics
☐ Imaging
☐ Infectious Disease
☐ Internal Medicine
☐ Laboratory
☐ Mohs
☐ Nephrology
☐ Neurology
☐ Nutrition
☐ Occupational Medicine
☐ Oncology/Hematology
☐ Ophthalmology
☐ Physical Medicine
☐ Pulmonary
☐ Research
☐ Rheumatology
☐ Surgery
☐ Wound Care
☐ Other: _____

BMC Referral Department
1501 NE Medical Center Dr.
Bend, OR 97701
Phone: (541) 706-2481
Fax: (541) 706-6474

For Referral Request Form refills please call (541) 706-2481.

Date: _____

Patient Information

Patient Name: _____

D.O.B. _____ Phone Number: _____

☐ Interpreter needed Language: _____

Referral Information

Referring to Provider: _____

Diagnosis Description: _____

ICD-10 Code(s): _____

Priority

☐ Urgent (24 hours) ☐ High (3-4 days) ☐ Routine

Comments: _____

Referring Provider: _____

Referring Facility: _____

Phone: _____ Fax: _____

Please Note: The Referral Department will process demographic and insurance information. Once completed, the Referral Department will notify the referring provider of appointment date and time.