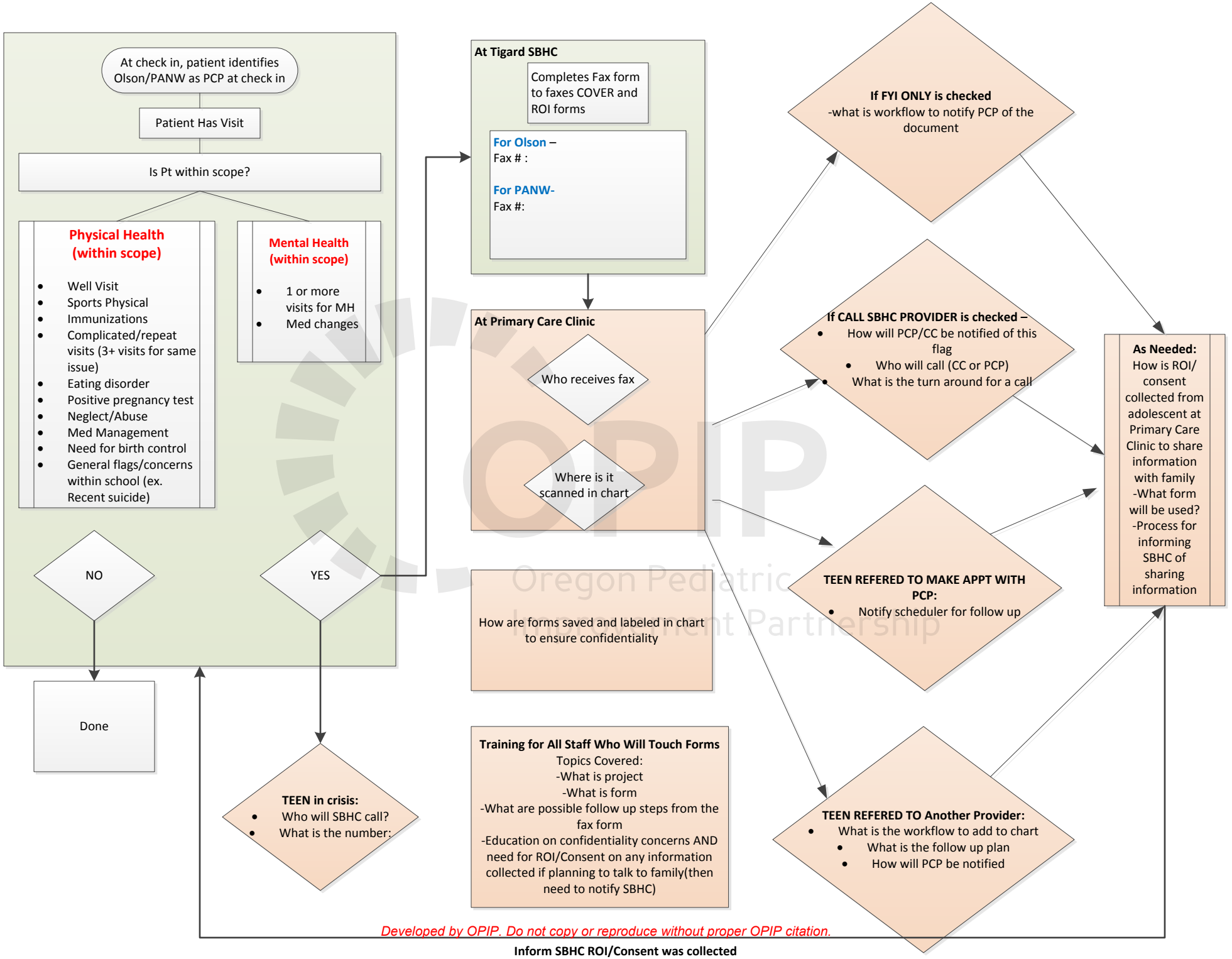

Pediatrics Associates of the Northwest
Fax Number: (503) 227-0676

CONFIDENTIAL COMMUNICATION
Virginia Garcia's Tigard High – School Based Health Center

PLEASE ATTACH ROI/CONSENT FORM

Name:
DOB:
Insurance: _____

☐**Assigned Patient - Needs to establish care** ☐**New patient - Needs to establish care**

Date of Visit at Tigard HS SBHC:
Provider Seen:

☐**Elizabeth Pruett, PNP** ☐**Gina Batliner, MA**

Contact Information for Youth:
Phone: _____ ☐ **Did not consent to release phone #**
Primary Care Provider Identified :
_____ ☐ **Did not know provider name**

Summary of Visit		
Type of Provider	☐ **Physical health provider**	☐ **Mental Health Provider**
Type of Visit	☐ **Well Visit** ☐ **Sports Physical** ☐ **Immunizations** ☐ **ED Follow-Up** ☐ **Sick-Visit** ☐ **Follow-up to referral from PCP** ☐ **Other:**	☐ **Mental health assessment** ☐ **Follow-up to referral from PCP** ☐ **Other:**
Reason for Visit		
Problem List and/or Diagnosis		
Medications Noted by Teen	☐ **None** ☐	☐ **None** ☐
Results of Labs and Positive Screens	☐ **None** ☐	☐ **None** ☐
Follow-Up Steps Needed	☐ **FYI ONLY – No follow up needed** ☐ **Call SBHC provider** _____ ☐ **Teen referred to make appt with PCP** ☐ **Teen referred to another provider Who:** ☐ **Other:**	☐ **FYI ONLY – No follow up needed** ☐ **Call SBHC provider** _____ ☐ **Teen referred to make appt with PCP** ☐ **Teen referred to another provider Who:** ☐ **Other:**
Other Information For Provider		

Fax #: **(503) 431-5776**

DRAFT 5/11/16

CONFIDENTIAL COMMUNICATION

Virginia Garcia's Tigard High – School Based Health Center

PLEASE ATTACH ROI/CONSENT FORM

Name:
DOB:
Insurance: _____
Date of Visit at PANW: _____
Provider Seen: _____

Referral Form from Pediatric Associates of the Northwest to Tigard HS SBHC		
Provider Referring To	☐ **Physical Health Provider**	☐ **Mental Health Provider**
Relevant Problem List and/or Diagnosis		
Relevant Medications for Referral	☐ **None** ☐	☐ **None** ☐
Reason for Referral to Tigard SBHC	☐ **HPV follow up** First administration date: ☐ **Meningococcal Booster** Booster needed on: ☐ **Weight check** Recommended periodicity: ☐ **BP check** ☐ **Other:**	☐ **MH screening follow-up**
Other Information For SBHC Staff	☐ **Call PANW Provider:** **_____**	☐ **Call PANW Provider:** **_____**
Information Requested Back	☐ **No follow up needed** ☐ **If you are unable to get them in by: (insert date)** ☐ **Summary of Visit**	☐ **No follow up needed** ☐ **If you are unable to get them in by: (insert date)** ☐ **Summary of Visit**