ORHP

VASECTOMY REFERRAL FORM

To be completed by RHCare or CCare clinic staff for the purposes of referring client for vasectomy services. Please complete all relevant fields.

Date of Referral: _____

RH Clinic

Name:	
Phone:	Fax:
Contact Name:	

Client

Name:			DOB:
Address:			
City:	State:	Zip:	Phone:

Vasectomist

Name:		
Address:		
City:	State:	Zip:
Phone:	Fax:	

Services

☐ Referred for Counsel	☐ Referred for Vasectomy
Date of Counsel (if performed/scheduled):	
Date of Vasectomy (if scheduled):	

Source of Pay

☐ Private Insurance	☐ OHP	☐ RH Access Fund	☐ OVP/Self-Pay
Amount Client Owes for Counsel:		Amount Client Owes for Vasectomy:	

Date Referral Sent: _____

Referral Expiration Date (180 days after Counsel): _____