



Oregon ScreenWise Program

971-673-0581 • ScreenWise.info@dhsosha.state.or.us
www.healthoregon.org/screenwise

ScreenWise Services Referral

Issue date: _____

Referral Information:

Referring Clinic: _____

Provider Name: _____

ScreenWise Patient Information:

Patient Name: _____

Patient DOB: _____

Patient ID: _____

Services Ordered:

Notes:

Facility Referred To:

Name: _____

Phone Number: _____

Address: _____

Appointment Time: _____