

**VASECTOMY REFERRAL FORM
Oregon Health Authority
Oregon Vasectomy Project**

To be completed by RH Clinic 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

<input type="checkbox"/> Referred for Counsel	<input type="checkbox"/> Referred for Vasectomy
Date of Counsel (if performed/scheduled):	
Date of Vasectomy (if scheduled):	

Source of Pay

<input type="checkbox"/> Private Insurance	<input type="checkbox"/> OHP	<input type="checkbox"/> CCare	<input type="checkbox"/> OVP/Self-Pay
Amount Client Owes for Counsel:		Amount Client Owes for Vasectomy:	

Date Referral Sent: _____

Referral Expiration Date (180 days after Counsel): _____