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

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

Source of Pay

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

Date Referral Sent: _____

Referral Expiration Date (180 days after Counsel): _____