OHSU Health Services

Sapphire Gateway Request Form

Please complete all fields and email to ohsuhshrs@ohsu.edu

Incomplete requests will not be processed.
Please complete as fillable PDF – handwritten requests will not be accepted.

Member and Provider Information

Member Name: _____ Date: _____

Member ID: _____ DOB: _____

Requestor Name: _____ Facility Name: _____

Requestor Phone: _____ Admit Date(s): _____

Admit Diagnoses: _____

Referral Information

Insurance Coverage:
☐ HSO/OHSU Health Services

Request:
☐ Length of stay requested (30-day max): _____

OHSU Health Services RCP requirements:
☐ Member agrees to engage in medical care
☐ Member agrees to engage with Health Services Care Manager during stay

Requestor has reached out to Sapphire Gateway staff to ensure room is available: ☐ Yes ☐ No
Anticipated check-in date to Sapphire Gateway: _____

Contact - Kathleen Kehl Ph: 971-303-6005 Email: kkehl@sapphirehealthservices.com

Anticipated goals and objective of stay:

Indicate care that is been ordered for member:
☐ Wound care ☐ Occupational Therapy ☐ Physical Therapy ☐ OP Infusion
☐ Home Health (list provider): _____ ☐ Other: _____

Please list any additional referrals or services planned for post-discharge care: