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Reproductive Endocrinology • Infertility

Douglas J. Austin, M.D.
Susan Armstrong, N.P.
Michelle Brookey, N.P.

Referral Form

Referring to: Douglas Austin, M.D. Susan Armstrong, N.P. Michelle Brookey, N.P.

Patient's Full Legal Name: _____

Date of Birth: ____/____/____ Telephone Number: _____

Address: _____

Reason for Referral: _____

Request(s):

Schedule patient a consultation for:

- Endocrine Infertility Menopause Transgender Services

Timeline: _____

Referring Provider: _____ Prepared by: _____

Contact Number: _____ Date: _____

Additional Information: _____

Once completed please fax to (541) 683-1709