

NEW PATIENT REFERRAL

Department of Hematology, Medical Oncology

Basil Bakir, MD PhD Travis Brachtenbach, DO Scott Cole, MD Melinda Dunlap, MD M. Byron Jennings, MD
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Department of Malignant Hematology

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PLEASE PRINT CLEARLY

Referring Provider: _____
Contact Person: _____ Phone #/Ext: _____

Refer to Department of Medical or Radiation Oncology for First Available: ☐

Medical _____ Radiation _____ (Please check correct one.) **OR**

If requesting specific provider, please indicate here (subject to availability): _____
NOTE: If the provider is not available due to schedule, OCSRI will assign the patient to another provider and notify your office.

Check below **only** if patient would prefer services through our satellite office:
_____ Bartlesville Office

Check ALL that apply:
_____ Biopsy pending Pathology
_____ Confirmed diagnosis
_____ Other _____
_____ Other _____

Patient's Name: _____ DOB: _____
Reason for Referral/Diagnosis (Please be specific; details will help triage urgency):

Please provide the information requested below to ensure timely processing. Please mark all that apply or N/A if records do not exist. *If test results (lab, imaging, etc.) are pending please document.

☐	Patient Demographics, including all phone numbers and authorization/referral if required
☐	Legible copy of Insurance Card, front and back
☐	Pathology confirming above diagnosis
☐	Any Imaging Results: CT Scan, Ultrasound, PET/CT, MRI, etc. (Circle what applies)
☐	Recent Progress/Procedure Notes from referring provider
☐	All previous operative reports available to the patient should be obtained
☐	Other records may be obtained at Dr. _____ office or _____ hospital
☐	Recent labs related to referral to OCSRI
☐	Previous oncology records if applicable

**Please fax this cover sheet with requested demographics and records to (918) 592-3809 or
email us at NewPatientReferrals@OCSRI.org**