

NEW PATIENT REFERRAL

Department of Gynecologic Oncology

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Refer to Department of Gynecologic Oncology Effective 77/179 patients will be scheduled with the first available surgeon to allow access to care unless previously discussed with a specific provide CHECK IF APPLICABLE Stiltwater Office (Dr. Thomas) Colpo Clinic (Dr. Gold) Patient's name: DOB: Reason for referral: (Please be specific; we schedule based on clinical triage information.) Other: DOB: CHECK ALL THAT APPLY Endometrial Cancer Endometrial Cancer Abnormal Pap Endometrial Cancer Abnormal Vaginal Bleeding Uterine Fibroids or Tumors Cervical/Vaginal Dysplasia Ovarian Cancer (Confirmed/Suspected) Vulvar Cancer Large Petvic Mass Gervical Cancer Complex Cysts Gest. Trophoplastic Neoplasm Elevated CA-125 Gest. Trophoplastic Neoplasm Elevated CA-125 Genetic Predisposition to GYN Cancer (BRCA+) Patient's primary insurance: D#: Group #: Phone #: Medicaid referral initiated? Yes No Referrals will NOT be processed without the following information. Please mark all that apply or N/A if record on not exists. If test results (lab, imaging, etc.) are pending please document. Patient demographics, including all phone numbers Legible copy of insurance card Pathology confirming above diagnosis Papa smear results (any available including normal) Any imaging results: CT scan, Ultrasound, PET/CT, MRI, etc. (check all that apply) Patient should arrive to appointment with a CD copy of imaging for review Progress/procedure notes from referring provider All previous operative reports available to the patient should be obtained	PLEASE PRINT CLEARLY	eferral Form: Fax to 918-592-3809
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