

**Department of Gynecologic Oncology**

CHECK IF APPLICABLE

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PLEASE PRINT CLEARLY

**Referral Form: Fax to 918-592-3809**

Referring provider: \_\_\_\_\_

Office contact person: \_\_\_\_\_ Phone # or ext: \_\_\_\_\_

Refer to Department of Gynecologic Oncology

Patients will be scheduled with the first available surgeon to allow access to care unless previously discussed with a specific provider.

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Reason for referral: (Please be specific; we schedule based on clinical triage information.)**

Other: \_\_\_\_\_

CHECK ALL THAT APPLY

- |   |   |
|---|---|
| <input type="checkbox"/> Abnormal Pap                 | <input type="checkbox"/> Endometrial Cancer                           |
| <input type="checkbox"/> Abnormal Vaginal Bleeding    | <input type="checkbox"/> Uterine Fibroids or Tumors                   |
| <input type="checkbox"/> Cervical/Vaginal Dysplasia   | <input type="checkbox"/> Ovarian Cancer (Confirmed/Suspected)         |
| <input type="checkbox"/> Vulvar Cancer                | <input type="checkbox"/> Large Pelvic Mass                            |
| <input type="checkbox"/> Cervical Cancer              | <input type="checkbox"/> Complex Cysts                                |
| <input type="checkbox"/> Gest. Trophoblastic Neoplasm | <input type="checkbox"/> Elevated CA-125                              |
| <input type="checkbox"/> Endometrial Hyperplasia      | <input type="checkbox"/> Genetic Predisposition to GYN Cancer (BRCA+) |

Patient's primary insurance: \_\_\_\_\_

ID #: \_\_\_\_\_ 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 records do not exist. 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
- \_\_\_\_ Pap 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
- \_\_\_\_ Other records may be obtained at Dr. \_\_\_\_\_ office or \_\_\_\_\_ hospital