OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

PH: 918-505-3200
www.ocsri.org

NEW PATIENT REFERRAL

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

- ☐ Abnormal Pap
- ☐ Abnormal Vaginal Bleeding
- ☐ Cervical/Vaginal Dysplasia
- ☐ Vulvar Cancer
- ☐ Cervical Cancer
- ☐ Gest. Trophoplastic Neoplasm
- ☐ Endometrial Hyperplasia
- ☐ Endometrial Cancer
- ☐ Uterine Fibroids or Tumors
- ☐ Ovarian Cancer (Confirmed/Suspected)
- ☐ Large Pelvic Mass
- ☐ Complex Cysts
- ☐ Elevated CA-125
- ☐ 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 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
____ 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

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