OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

PH: (918) 505-3200
WWW.OCSRI.ORG

DEPARTMENT OF MEDICAL ONCOLOGY/HEMATOLOGY

Scott Cole, MD	Melinda Dunlap, MD	M. Byron Jennings, MD	Ali Moussa, MD
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	Christopher Manus, MD	Caleb Scheckel, DO	

DEPARTMENT OF RADIATION ONCOLOGY

Joshua Garren, MD	Grenville Jones, MD	M. Connie Nguyen, MD	Leslie Yonemoto, MD

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 @ 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.