The Cancer Center AT SMC

610 S. Walnut Street Stillwater OK 74074

PHONE (405) 533-1985

FAX (405) 533-1958

DATE OF REFERRAL
COMPLETED BY:

AKINOLA OGUNDIPE, MD

NEW PATIENT REFERRAL CHECKLIST

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MI)
ADDRESS (STREET, CITY, STATE, ZIP+4)
PRIMARY PHONE
MESSAGE PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE	ID
SECONDARY INSURANCE	ID
PATIENT DOB	PATIENT SSN
SUBSCRIBERS' NAME	SUBSCRIBER DOB
RELATIONSHIP TO SUBSCRIBER	GROUP/EMPLOYER

PRIMARY PHYSICIAN / REFERRING PHYSICIAN

REFERRING PHYSICIAN

PHYSICIAN'S NAME (LAST, FIRST, MI)
ADDRESS (STREET, CITY, STATE, ZIP+4)
PRIMARY PHONE / FAX (PH) (F)
NPI

PRIMARY CARE PHYSICIAN (If Different from Referring)

PHYSICIAN'S NAME (LAST, FIRST, MI)
ADDRESS (STREET, CITY, STATE, ZIP+4)
PRIMARY PHONE / FAX (PH) (F)
NPI

REASON FOR REFERRAL / CONSULT

Please attach most recent documents (within 6 months), if available:

Patient Demographics	☐	Pathology Report (PET/CT/MRI)	☐	Current Treatment Plan	☐
Office / Progress Notes	☐	Radiology Report (Xrays, Scans)	☐	Hospital Discharge	☐
Laboratory Report	☐	Operative Report	☐	Medication List	☐

FOR OFFICE USE ONLY

Date of Initial Appointment: _____

INSURANCE VERIFIED		MEDICAL RECORDS REVIEWED		APPOINTMENT CONFIRMED	
DATE	INITIAL	DATE	INITIAL	DATE	INITIAL