Request for Appointment at OUCP Central Scheduling

Today's Date_____

Patient Name_____ M or F (circle one) Patient DOB:_____

Patient SSN:_____Address:_____

City, State_____ Zip:_____Home Phone:_____

Parent(s) Name:_____ SSN:_____

Primary Phone:_____ Cell Phone:_____

Other Emergency Contact:_____Relationship to child:_____

Primary Phone:_____Secondary Phone:_____

Insurance Information: Please send a front and back copy of patient's insurance card

Referral Information

Referring Physician:_____Phone#_____

Office Contact Name:_____ Fax# _____

Request for Appointment with which OU Children's Physician provider or clinic? _____

*Diagnosis/Reason for visit:_____

*Reason/Intent for visit:" Consult _____ Transfer of care _____

Requesting Provider's name (printed) & signature: _____/_____
(Signature required for Consult Only)

***REQUIRED FIELD!** **NOTE:** if consultation is requested please keep a copy of this form in your patients chart and/or document the request in their medical record!!!!

Attached Referral (if required by insurance): Y or N Attached Medical Records: Y or N

Once the appointment has been scheduled we will fax it back to you with the appointment date and time.

For OUCP Office Use
Appointment Date and Time: _____ with_____
Patient notified: Y or N