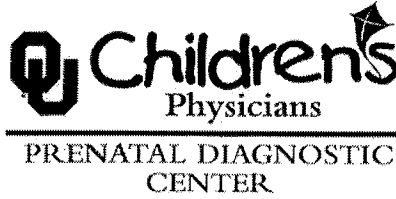


**Clinic Staff User Only:**

Appt Date: \_\_\_\_\_

Appt Time: \_\_\_\_\_ (AM/PM)



MR# ASSIGNED: \_\_\_\_\_  
 PT CALLED: Y \_\_\_\_\_ N \_\_\_\_\_  
 FAXED CLINIC: Y \_\_\_\_\_ N \_\_\_\_\_  
 CLINIC CALLED: Y \_\_\_\_\_ N \_\_\_\_\_  
 SCHEDULER: \_\_\_\_\_  
 DATE: \_\_\_\_\_

PHONE: (405) 271-5400 FAX: (405) 271-5696  
 1200 N. Phillips Ave (Children's Avenue) Suite 1A  
 Oklahoma City, OK 73104

**REFERRAL SHEET**

Patient Name: \_\_\_\_\_ Home / Cell: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_ LMP: \_\_\_/\_\_\_/\_\_\_ EDC: \_\_\_/\_\_\_/\_\_\_ BMI: \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_ Primary Language: \_\_\_\_\_ BLOOD TYPE: \_\_\_\_\_  
 Insurance Information:

**(PLEASE ATTACH A COPY OF PATIENT'S INSURANCE CARD AND DRIVERS LICENSE TO THIS REFERRAL SHEET (FRONT & BACK))**

**INDICATIONS / DIAGNOSIS:** \_\_\_\_\_  
 (PLEASE INCLUDE "ALL" PRENATAL RECORDS, LAB RESULTS, AND ANY PREVIOUS US RESULTS WITH THIS REFERRAL.)

**MATERNAL HISTORY OF:** \_\_\_\_\_

**SCHEDULING INSTRUCTIONS:**  PRIORITY (24 - 48 HOURS)  URGENT (explain): \_\_\_\_\_

<p><b>OBSTETRIC ULTRASOUND:</b> ** <input type="checkbox"/> Singleton <input type="checkbox"/> Multiples (# ___)</p> <p><input type="checkbox"/> First Trimester Viability  <input type="checkbox"/> First Trimester w/Nuchal Translucency  <input type="checkbox"/> Level I - Size and Dates (ultrasound ONLY no MFM consult)  <input type="checkbox"/> Level II (45 min MFM consult w/US)  <input type="checkbox"/> Follow-up/Growth (frequency: _____)  <input type="checkbox"/> Other: _____</p> <p><b>(** Perinatal consult if abnormality found on ultrasound)</b></p>	<p><b>DIABETES SERVICES:</b>  <b>Type of Diabetes:</b>  <input type="checkbox"/> Gestational  <input type="checkbox"/> Type 1  <input type="checkbox"/> Type 2  <input type="checkbox"/> Other: _____</p> <p><b>Co-Management:</b>  <b>*** PLEASE NOTE ***</b>        Patient will be seen for diabetes education <b>ONLY</b> if she is a transfer of care. Otherwise, patient will need to be referred to HAROLD HAMM DIABETES CENTER for diabetes education (405)271-3455.</p>
<p><b>ANTENATAL TESTING:</b>  <input type="checkbox"/> BPP (specify frequency): _____  <input type="checkbox"/> AFI (specify frequency): _____  <input type="checkbox"/> NST (specify frequency): _____</p>	<p><b>OBSTETRICAL SERVICES:</b>  <input type="checkbox"/> Complete Transfer of Care  <input type="checkbox"/> New OB Visit  <input type="checkbox"/> Please sent updates on patient care</p>
<p><b>CONSULTS AND OTHER SERVICES:</b>  <input type="checkbox"/> Consultation with Diagnostic Testing as Clinically Indicated (explain): _____  <input type="checkbox"/> Co-Management with Diagnostic Testing (explain): _____  <input type="checkbox"/> Maternal-Fetal Medicine Consultation (explain): _____  <input type="checkbox"/> Genetic Counseling (explain): _____</p>	
<p>Referring Physician: _____        Contact Person: _____ Contact Phone: _____        Fax Number: _____ Date of Referral Request: _____</p>	

**ATTENDING PHYSICIAN SIGNATURE / DATE:** \_\_\_\_\_