OU Health | Stephenson Cancer Center

A Department of University of Oklahoma Medical Center

New Patient Consult Form

Fax completed form and patient records to (405) 271-1913.

From

Referring Physician:_____ Practice Name:_____
(Please Print)

Address:_____ City:_____ State:_____ Zip:_____

Phone#: (____)_____ Fax#: (_____)_____ E-Mail:_____

Practice Contact:_____ Self Referral ☐

Patient Information

Name: *Last_____ *First_____

Is the patient aware of the referral to Stephenson Cancer Center? ◯ Y ◯ N

Gender: ◯ M ◯ F *DOB: _____

Telephone: *Home (____)_____ Work: (____)_____ Other: (____)_____

Address:_____ City:_____ State:_____ Zip:_____

Primary Insurance_____ Secondary Insurance_____

Diagnosis and Reason for Consult or Treatment

Reason For Consult

Diagnosis and Disease Site:

_____

Are you requesting any of the following?

☐ 2nd Opinion ☐ Proton Therapy ☐ Stem Cell /Transplant / Cellular Therapy ☐ Phase 1 Clinical Trial

Are you requesting a specific physician?_____

Fax Documents to (405) 271-1913

Fax these items to our team at (405) 271-1913:

☐ Completed New Patient Consult Form

☐ Patient Records: Most Recent H&P, Progress Notes(last 3-6 months), Lab Results, Current Medication List

☐ Patient Imaging Reports related to the Diagnosis ☐ Imaging has not been completed

☐ Patient Pathology Reports related to the Diagnosis ☐ Pathology has not been completed

Imaging Disks & Pathology Slides

☐ Mail Patient Imaging Disks to:
OU Stephenson Cancer Center
Floor 1 Radiology
800 NE 10th Street
Oklahoma City, Oklahoma, 73104
Tel: (405) 271-4889

☐ Mail Patient Pathology Slides to:
OU Medical Center
Lower Level Surgical Pathology
700 NE 13th street
Oklahoma City, Oklahoma, 73104
Tel: (405) 271-5653

If Imaging and Pathology not completed at referring facility, please list the name and contact information for the entity that has the patient's pathology slides and imaging disks.

☐ **Imaging Disks** ☐ **Pathology Slides**

Facility Name:_____ Facility Name:_____

Telephone Number:( )_____ Telephone Number:( )_____

Fax Number:( )_____ Fax Number:( )_____

*Required Field