

OKLAHOMA DEPARTMENT OF CORRECTIONS
OUTSIDE REFERRAL RECORD

PART B - To be completed by consulting physician/provider

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| INMATE NAME: | ODOC NUMBER: | FACILITY: |
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SIGNIFICANT FINDINGS/TEST RESULTS

MEDICATIONS RECOMMENDED (Outside Providers are **NOT** to write prescriptions for narcotics.) They are not routinely available. If recommended, please consult with the referring provider. Please do not write prescriptions for a seven day supply.

_____ DATE _____ PROVIDER NAME (PLEASE PRINT) _____

Please provide appropriate documentation for continuity of care. For all emergency care please provide emergency room record or report and for all inpatients, stays please provide discharge summary to the referring facility when completed.

ADDITIONAL REFERRAL NEEDED

Yes NO TYPE: _____ PROVIDER: _____ PHONE: _____

IF yes, the appointment will be made by the referring ODOC Facility, unless it is an emergency. Please contact the referring ODOC Facility before transferring the inmate to another outside provider.

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|----------------------------------|-----------------------------------|-----------------------|
| FOLLOW-UP APPOINTMENT DATE _____ | FOLLOW-UP APPOINTMENT TIME: _____ | AM/PM LOCATION: _____ |
|----------------------------------|-----------------------------------|-----------------------|

This visit must be approved by the Regional Physician, if not approved you will be contacted.

FOR SECURITY REASONS DO NOT ADVISE INMATE OF ANY APPOINTMENT DATES