OKLAHOMA DEPARTMENT OF CORRECTIONS OUTSIDE REFERRAL RECORD SUMMARY

Appointment Date:		Appointment Time:			Location:								Type of Visit: (Check appropriate box)					
			All	M/PM										Schedu	led	□ E	mergency	
						nsported By DOC Vehicl		□ Amb	ulance	• 🗆	Medi	flight		Inpatien	ıt	0	utpatient	
PART A -	To be compl	eted by refe	rring facili	ty.														
INMATE NAME:					ODOC NUMBER:				SOCIAL SECURITY #:			TY #:	DOC FACILI			TY:		
								-	DATE	OF B	IRTH	:		FACIL	ITY P	HONE	NUMBER:	
AGE	GENDER	RACE WT			HT B/P			P	ULSE		HOW LONG HAS T			THE PROBLEM EXISTED:				
DRUG/FOOD SENSITIVITY/ALLERGIES: YES (SPECIFY)					I NO □						DID THE PROBLEM EXIST PRIOR TO INCARCERATION: YES IN NO INCARCERATION:							
☐ Med	lically Mandat	ory/Emerge	ncy	<u> </u>	Medica	Illy Necess	ary) Me	edical	ly Ac	ceptable	Ţ	Ele	ctive/	Cosme	etic Surgery	
CURREN'	T MEDICATIO	N (S) AND S	IGNIFICAN	NT MEC	DICATIO	ON HISTOF	RY AN	D MED	ICAL T	TREA	TMEN	IT .						
PERTINE	NT PHYSICAL	. FINDINGS																
DOES TH	E INMATE AD	HERE TO T	HE TREAT	MENT	PLAN:	YES	<u> </u>		NO			(EXPL	AIN)					
					_	D.A	ATE		N	/IEDIC	AL P	ROVIDER	R NAN	ΛΕ (PL	.EASE	PRIN	T)	
	utside referi ncluding cu									pleas	e sei	nd all pe	rtine	nt docı	umen	tation	ı for contin	uity
TO BE 0	OMPLETED	BY AUTHOR	IZING REC	GIONAL	L PHYS	SICIAN												
APPRO	VED: YES		ю			LIND	SAY			OU M	EDIC	AL CENT	ER		LC	CAL		
	Date						Reg	jional F	Physic	ian (P	lease	Print)						
Referral	Form Will Be	Return to F	acility Med	dical Pı	<u>rovi</u> der	within Sev	ven W	orking	Days									
	Chief Medica																	

OKLAHOMA DEPARTMENT OF CORRECTIONS OUTSIDE REFERRAL RECORD

PART B - To be completed by consulting physician/provider INMATE NAME: **ODOC NUMBER:** FACILITY: 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** 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.

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

FOLLOW-UP APPOINTMENT TIME:

FOLLOW-UP APPOINTMENT DATE

AM/PM LOCATION: