OKLAHOMA
Health Care Authority

DOULA SERVICES

REFERRAL FORM

Referral by:

Phone:

Referral Date:

REFERRAL SOURCE:					
	Primary Care Provider		Specialty Provider		Physician Assistant
	Advanced Practice Registered Nurse		Certified Nurse Midwife		

MEMBER INFORMATION:							
Member Name:					Member ID:		
Member DOB:					Member Phone:		
Contact Name:					Contact Phone:		
Relationship to Member:		Self		Family		Other *(specify)*:	

REASON FOR REFERRAL:

PLEASE DESCRIBE CONCERNS AND ATTACH RELEVANT MEDICAL RECORDS. ATTACHING RELEVANT MEDICAL RECORDS WILL EXPEDITE REFERRAL PROCESS.

Instructions

1. Complete and mail/fax the original copy of the form to the provider to who you are referring.
2. Keep a duplicate copy for your records in the member's medical chart.

PLEASE DO NOT MAIL/FAX A COPY TO OHCA. DO NOT ATTACH A COPY TO YOUR CLAIM FORM.

OHCA Revised 5/9/2023