



OKLAHOMA
Health Care Authority

DOULA SERVICES
REFERRAL FORM

Referral by:

Phone:

Referral Date:

REFERRAL SOURCE:

<input type="checkbox"/>	Primary Care Provider	<input type="checkbox"/>	Specialty Provider	<input type="checkbox"/>	Physician Assistant
<input type="checkbox"/>	Advanced Practice Registered Nurse		<input type="checkbox"/>	Certified Nurse Midwife	

MEMBER INFORMATION:

Member Name:				Member ID:			
Member DOB:				Member Phone:			
Contact Name:				Contact Phone:			
Relationship to Member:	<input type="checkbox"/>	Self	<input type="checkbox"/>	Family	<input type="checkbox"/>	Other <i>(specify)</i> :	

REASON FOR REFERRAL:

Empty box for Reason for Referral.

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

Empty box for concerns and medical records.

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



ADDRESS

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105



WEBSITES

oklahoma.gov/OHCA
mysooner.org



PHONE

Admin: 405-522-7300
Helpline: 800-987-7767