



**Request for Appointment at OUCP Central Scheduling**

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ M or F (circle one) Patient DOB: \_\_\_\_\_

Patient SSN: \_\_\_\_\_ Address: \_\_\_\_\_

City, State \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

**Insurance Information: Please send a front and back copy of patient's insurance card**

**Referral Information**

Referring Physician: \_\_\_\_\_ Phone# \_\_\_\_\_

Office Contact Name: \_\_\_\_\_ Fax# \_\_\_\_\_

Request for Appointment with which OU Children's Physician provider or clinic? \_\_\_\_\_

\*Diagnosis/Reason for visit: \_\_\_\_\_

\*Reason/Intent for visit: Consult \_\_\_\_\_ Transfer of care \_\_\_\_\_

Requesting Provider's name (printed) & signature: \_\_\_\_\_ / \_\_\_\_\_  
(Signature required for Consult Only)

**\*REQUIRED FIELD! NOTE:** if consultation is requested please keep a copy of this form in your patients chart and/or document the request in their medical record!!!!

**Attached Referral (if required by insurance): Y or N Attached Medical Records: Y or N**

**Once the appointment has been scheduled we will fax it back to you with the appointment date and time.**

**For OUCP Office Use**  
**Appointment Date and Time:** \_\_\_\_\_ **with** \_\_\_\_\_  
**Patient notified: Y or N**