OU Children's Physicians

HEART CENTER CLINIC
1200 CHILDREN'S AVENUE, SUITE 2F
OKLAHOMA CITY, OK 73104
PHONE: 405.271.5530

Pediatric Cardiology Referral Request

Attn: Heart Center Clinic Scheduling Team
Tel: 405.271.5530 – Option 2

FAX COMPLETED REQUEST TO:
405.271.2034

(Please Print)

Patient Information

Last Name	First Name	MI	Date of Birth	Age	M/F

Street Address	City	State	Zip Code

Parent/Guardian Name	Relationship to Patient	Preferred Contact Number: ☐ Cell ☐ Home

Translator needed for patient:	☐ Yes ☐ No	If yes, list language:	
Translator needed for parent/guardian:	☐ Yes ☐ No	If yes, list language:	

Referring Provider Information ☐ PCP ☐ Subspecialist

Provider Name	☐ MD ☐ NP ☐ PA	Subspecialty

Name of Practice	Practice Contact (name)

Practice Address	Office Phone	Office Fax

Reason for Referral

☐ New Patient ☐ Established Patient ☐ 2nd Opinion ☐ Procedure Only (*list CPT and description below*)

CPT Code(s)	CPT Description(s)

Clinical Indications/Symptoms for Referral:

ICD10				.					(enter a minimum of 3 and maximum of 7 characters)
ICD10				.					(enter a minimum of 3 and maximum of 7 characters)

Please fax all pertinent clinical documents listed below along with this referral request
(e.g., clinic notes, progress notes, medication history, diagnostic reports, etc.)

Insurance Information

Insurance Type	☐ HMO	☐ Medicaid	☐ Tricare	☐ Other (specify):	
	☐ PPO	☐ Medicare	☐ Self-Pay	Prior Authorization Required:	☐ Yes ☐ No

Authorization #	Approved # of Visits	Expiration Date

Guarantor Name	Relationship to Patient	Contact Number: ☐ Cell ☐ Home

Please fax a legible copy of the insurance card (both sides) and authorization (if required)

Form Completed By (Name)	Position/Title	Date