



Referral Coordinators: Kristi Franklin (918)301-3114
Heather Breshears (918) 301-3128

Referral Fax (918) 301-4220
Email: referrals@toctulsa.com

REFERRAL FORM:

Dr. / Clinic: _____

Contact Name: _____ Email: _____

Clinic / Office Address: _____ Phone #: _____

_____ Fax #: _____

REFERRAL TO:

Schedule Patient listed below w/ Dr.

<input type="checkbox"/> James Bischoff, MD	<input type="checkbox"/> Yogesh Mittal, MD
<input type="checkbox"/> Brian Chalkin, DO	<input type="checkbox"/> Lisa Mogelnicki, DPM
<input type="checkbox"/> Chad Hanson, DO	<input type="checkbox"/> Victor Palomino, DO
<input type="checkbox"/> Greg Holt, MD	

Location: ☐ Midtown (Orthopaedics & some injections)

Patient can see PA on 1st Visit: ☐ Yes ☐ No

Chief Complaint

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SS# _____ Phone # _____

Cell #: _____ Work # _____ Male ☐ Female ☐

Address: _____

Alternate Contact Name: _____

Relationship: _____ Phone # _____

INSURANCE INFORMATION: (If Work Comp please check here ☐)

Insurance: _____ Policy # _____

Policy Holder: _____ Policy Holder DOB _____

Group #: _____

Authorization: _____

SPECIAL INSTRUCTIONS: