



OKLAHOMA DEPARTMENT OF CORRECTIONS  
OUTSIDE REFERRAL RECORD

PART B - To be completed by consulting physician/provider

INMATE NAME:	ODOC NUMBER:	FACILITY:
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**SIGNIFICANT FINDINGS / TEST RESULTS**

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**MEDICATIONS RECOMMENDED** (Outside Providers are **NOT** to write prescriptions for narcotics.) They are not routinely available. If recommended, please consult with the referring provider. Please do not write prescriptions for a seven day supply.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PROVIDER NAME (PLEASE PRINT)

Please provide appropriate documentation for continuity of care. For all emergency care please provide emergency room record or report and for all inpatients stays please provide discharge summary to the referring facility when completed.

**ADDITIONAL REFERRAL NEEDED**

Yes  NO TYPE: \_\_\_\_\_ PROVIDER: \_\_\_\_\_ PHONE: \_\_\_\_\_

IF yes, the appointment will be made by the referring ODOC Facility, unless it is an emergency. Please contact the referring ODOC Facility before transferring the inmate to another outside provider.

FOLLOW-UP APPOINTMENT DATE \_\_\_\_\_ FOLLOW-UP APPOINTMENT TIME: \_\_\_\_\_ AM / PM LOCATION: \_\_\_\_\_

This visit must be approved by the Regional Physician, if not approved you will be contacted.

**FOR SECURITY REASONS – DO NOT ADVISE INMATE OF ANY APPOINTMENT DATES**