

Department of Breast Surgery

DR. LAURIE FLYNN

PLEASE PRINT CLEARLY

Referral / Records Form: Fax to 918-592-3809

Referring provider: _____

Office contact person: _____ Phone # or ext: _____

Patient's name: _____ DOB: _____

Reason for referral: (please be specific; we schedule based on clinical triage information)

CHECK ALL THAT APPLY

- New Dx breast cancer
- Breast lump / mass
- Breast pain
- Nipple discharge
- Skin lesion
- High risk: genetic testing / family history
- Personal history of cancer

Abnormal breast imaging

- Birads 0 (incomplete), Birads 1 (negative), Birads 2 (benign)
- Birads 3 (probably benign), Birads 4 (suspicious)
- Birads 5 (highly suggestive of malignancy)
- Birads 6 (known biopsy-proven malignancy)
- Other: (please describe) _____

Has the patient been seen by Dr. Flynn previously? Yes No

Is the patient currently on blood thinner? Yes No

Patient's primary insurance: _____

ID #: _____ Group #: _____

Phone #: _____ Medicaid referral initiated? Yes No

Referrals will NOT be processed without the following information. Please mark all that apply or N/A if records do not exist. If test results (lab, imaging, etc.) are pending please document.

- ____ Patient demographics, including all phone numbers
- ____ Legible copy of insurance card
- ____ Pathology confirming above diagnosis
- ____ Mammogram / ultrasound results (any available including normal)
- ____ Any imaging results: CT scan, ultrasound, PET/CT, MRI, etc. (check all that apply)
- Patient should arrive to appointment with a CD copy of imaging for review if imaging not completed at St. John, Saint Francis or Hillcrest**
- ____ Progress / procedure notes from referring provider
- ____ All previous operative reports available to the patient should be obtained
- ____ Other records may be obtained at Dr. _____ office or _____ hospital