(808) 932-3730 Option #2 | (808) 974-6798 (Fax)

Official Use Only
Medical Record: ________________

New Patient Referral Form

Date: ______________

Patient Information:

Patient's Legal Name: Date of Birth:

______________	______________	______	______________
Last Name	First Name	M.I.	MM/DD/YYYY

Primary Phone No.: ____________________ Alternate Phone No.: ____________________

Primary Insurance: ____________________ Policy Number: ____________________

Secondary Insurance: ____________________ Policy Number: ____________________

Request:

☐ **STAT** – Provider to Provider call needed, call (808) 932-3730 Option #2

☐ **ROUTINE** – Processed and scheduled per routine protocol

Please include any <u>cardiac testing or previous records from cardiologist, operative report, EKG and Labs</u>. Also include <u>Authorization</u> for any cardiac testing ordered. Confirmation of patient's appointment date and time will be given upon receipt of all pertinent documents.

For Cardiology Referral (Please mark off what you are requesting for your patient):

- ☐ **Sports Cardiology Program Referral**
- ☐ **Consultation**
- ☐ **F/U Appointment (If seen within the past 3 years)**
- ☐ **ZIO Monitor (Up to 14-day monitor)**
- ☐ **PREVENTICE Monitor (Up to 14-day monitor)**
- ☐ **Treadmill Stress Test**
- ☐ **Lexiscan (Nuclear Stress Test)**
- ☐ **Treadmill Stress ECHO**
- ☐ **Dobutamine Stress ECHO**

Reason for Referral (include Diagnosis and ICD code):

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Referring Physician: ____________________ **Phone:** ________________ **Fax:** ____________

Signature: ________________________

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