



East Hawaii Health
134 Pu'uhonu
General Surgery

(808) 932-4225 | (808) 935-0904 (Fax)

New Patient Referral Form

Official Use Only
Medical Record: _____

Patient Information:

Date: _____

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) 932-4225
- ROUTINE-** Processed and scheduled per routine protocol
- SECOND OPINION/PREVIOUS SURGERY ON AFFECTED BODY PART-** Please send previous records if seen by another provider
- MVA/ NO FAULT/ WORKERS' COMP-** Please include Claim Number; Adjuster Name; Adjuster Phone Number and Date of Injury below

Please include the following to avoid delays in scheduling:

- ID, Insurance Card & Demographic Sheet
- Medical List, pertinent clinical notes, any pertinent diagnostics testing: labs, imagine (see referral guidelines for specifics)

Reason for Referral (include Diagnosis and ICD code):

Referring Physician: _____ **Phone:** _____ **Fax:** _____

Signature: _____