East Hawaii Health
Cancer Center

Official Use Only
Medical Record: _____

(808) 932-3590 | (808) 974-6864 (Fax)

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: _____

Referral to: ☐ **Medical Oncology** ☐ **Radiation Oncology**

Request:

☐ **STAT** – Provider to Provider call needed
For Radiation Oncology please dial (808) 932-3000 and press # to enter extension **1704**
For Medical Oncology, please dial (808) 932-3000 and press # to enter extensions **5718**

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

Confirmation of patient's appointment date and time will be given upon receipt of all pertinent documents.

For Oncology Referral, please include the following:

- ☐ **History and Physical**
- ☐ **Pathology Reports (All pathology reports)**
- ☐ **Operative Reports (if any)**
- ☐ **Discharge Summary (if applicable)**
- ☐ **Lab Reports**
- ☐ **Imaging (Diagnostic) Reports**
- ☐ **Previous Oncology Records (if treated elsewhere)**

Reason for Referral (include Diagnosis and ICD code):

_____

_____

_____

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