Official Use Only Medical Record: East Hawaii Health 1190 Waianuenue Orthopedics (808) 932-4235 | (808) 961-9504 (Fax) New Patient Referral Form Date: **Patient Information:** Date of Birth: Patient's Legal Name: 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) 932-4235 **ROUTINE** – Processed and scheduled per routine protocol SECOND OPINION - Please send previous Orthopedics records if seen by another provider **PREVIOUS SURGERY-** Please send operative report from previous operation 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, imaging (see referral guidelines for specifics) 🗆 BMI Reason for Referral (include Diagnosis and ICD code):

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