(808) 932-3860 | (808) 932-3865 (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) 932-3860

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

☐ **SECOND OPINION-** Please send previous records if seen by another provider

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:** ________________