East Hawaii Health
1190 Waianuenue
Audiology
(808) 932-3047 (Phone) | (808) 974-6732 (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** – Sudden hearing loss

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

Please include the following to avoid delays in scheduling:

☐ ID, Insurance Card & Demographic Sheet

☐ Pertinent clinical notes and any pertinent diagnostics testing: previous audiograms

Reason for Referral (include Diagnosis and ICD code):

{Please note our Audiology Clinic does not service hearing aids at this time. We are only performing diagnostic testing.}

Referring Physician: ______________________ **Phone:** ______________________ **Fax:** ______________

Signature: ______________________________