East Hawaii Health
73 Pu`uhonu
Vascular Surgery
(808) 932-3850 | (808) 932-3855 (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) 932-3850

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

☐ **SECOND OPINION-** Please send previous Vascular 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, imaging (see referral guidelines for specifics)

Reason for Referral (include Diagnosis and ICD code):

_____

_____

_____

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

Signature: _____