(808) 932-3665| (808) 933-0944 (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) 938-7461

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

Please include the following to avoid delays in scheduling:

☐ Any recent images and reports
☐ Recent lab results (CMP, CBC, PT INR)
☐ Recent office notes
☐ Short stay admit orders
☐ Diagnosis/ICD codes

Reason for Referral (include Diagnosis and ICD code):

Referring Physician: ________________ **Phone:** ________________ **Fax:** ________________

Referring Physician's Signature: ________________________________

Contact person's name, title and number/extension to call if any additional information is needed:

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Scheduling and confirmation of patient's appointment date and time will be given upon receipt of all pertinent documents.** ***Please note, ANY missing information may delay patient being scheduled in a timely manner. Any questions please call our clinic.