East Hawaii Health
1190 Waianuenue
Dermatology

(808) 932-3740 | (808) 932-3741 (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) 932-3740

☐ **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

☐ Medication List, pertinent clinical notes, any pertinent diagnostics testing: labs, pathology, imaging (see referral guidelines for specifics)

Reason for Referral (include Diagnosis and ICD code):

_____

_____

_____

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