(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:** _____