

Official Use Only	
Medical Record:	_

New Patient Referral Form

Patient Information:			Date.
Patient's Legal Name	:		Date of Birth:
Last Name	First Name	M.I.	. MM/DD/YYY
Primary Phone No.:	A	ternate Phone No	D.:
Primary Insurance:	Po	olicy Number:	_
Secondary Insurance:	Po	olicy Number:	
Request:			
STAT - Pi	ovider to Provider call needed, call	(808) 932-3730, op	otion #2
ROUTINE	– Processed and scheduled per rou	tine protocol	
SECOND another p	OPINION/FOLLOW-UP - Please send provider	previous Gastroe	enterology records if seen by
	S PROCEDURES - Please send previo y, if applicable	us colonoscopy an	nd EGD reports with
Please include the follo	owing to avoid delays in scheduling:		
☐ ID, Insurance Car	rd & Demographic Sheet		
☐ Medication list, p guidelines for sp	pertinent clinical notes, any pertiner ecifics)	t diagnostics testi	ing: labs, imaging (see referral
Reason for Referral (include Diagnosis and ICD code):		
Referring Physician:	Phone	:	Fax:

Form: 6177-1003-21 7/7/2021