David Ono, MD
Noah Solomon, MD
Nisha Christiansen, MD
Ahmed Rehan, MD
Arie Ganz, MD

Sorkko Thirunavukkarasu, MD
Leilani Ka'anehe, MD
Rick Hayashi, MD
Stephanie Gilibert, MD
Chintav Shah, MD

Hawaii Kidney Specialists

Ph: 808-523-0445 Fax: 808-356-3380
1520 Liliha St Suite 601
Honolulu HI 96817

NEW PATIENT REFERRAL FORM

Patient Name: _____ DOB: _____
Last First MI

Patient SSN: _____ Sex: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Cell: _____ Email: _____

Primary Language: _____ Interpreter needed? ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____ Phone #: _____

Primary Insurance: _____ Insurance Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance: _____ Insurance Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Referring Physician: _____ Phone: _____ Fax: _____

NPI #: _____ Contact Person: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Reason for Referral/Diagnosis: _____

PLEASE FAX THE FOLLOWING:

Attn: Ellen @ 808-356-3377

Patients <u>can not</u> be scheduled without this information

Please call (808) 523-0445

(option 3)

_____ Demographic Sheet
_____ Last year of Lab results
_____ Last Year of Progress Notes (H&P / Consult Notes)
_____ Imaging Studies (Ultrasound, CXR, EKG, etc.) - *if available*
_____ Medication List
_____ Immunization History - *if available*
_____ **FOR HMO/QUEST/TRICARE WEST PATIENTS, PLEASE SEND REFERRAL**

***** ALL REQUESTED DOCUMENTS MUST BE SENT TO EXPEDITE PROCESS *****

PATIENT WILL BE CONTACTED DIRECTLY TO SCHEDULE APPOINTMENT

For Office Use Only		
Date of Appointment: _____	Date:	Time:
Approved By:		