NEW PATIENT REFERRAL FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 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:** | | | | | |  | Demographic Sheet | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Attn: Ellen @ 808-356-3377** | | | |  | |  | Last year of Lab results | | | | | | | | | | | | | | | | | | | | | | | |  |
| ***Patients can not be scheduled without this information*** | | | |  | |  | Last Year of Progress Notes (H&P / Consult Notes) | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | |  | |  | Imaging Studies (Ultrasound, CXR, EKG, etc.) - *if available* | | | | | | | | | | | | | | | | | | | | | | | |  |
| ***Questions?*** | | | |  | |  | Medication List | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Please call (808) 523-0445** | | | |  | |  | Immunization History - *if available* | | | | | | | | | | | | | | | | | | | | | | | |  |
| **(option 3)** | | | |  | |  | **FOR HMO/QUEST/TRICARE WEST PATIENTS, PLEASE SEND REFERRAL** | | | | | | | | | | | | | | | | | | | | | | | |  |
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| **\*\*\* ALL REQUESTED DOCUMENTS MUST BE SENT TO EXPEDITE PROCESS \*\*\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***PATIENT WILL BE CONTACTED DIRECTLY TO SCHEDULE APPOINTMENT*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| For Office Use Only | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Appointment: |  | | | | | | | | | | | | | | Date: | | | | | | |  | | | | | | | Time: | | |
| Approved By: |  | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |