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:** |  | 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** |  |
|  |  |  |  |
|  |  |  |  |  |
| **\*\*\* 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: |  |  |  |