



(808) 932-3860 | (808) 932-3865 (Fax)

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/YYYY

Primary Phone No.: _____ Alternate Phone No.: _____

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Request:

- ☐ **STAT-** Provider to Provider call needed, call (808) 932-3860
- ☐ **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
- ☐ Medical List, pertinent clinical notes, any pertinent diagnostics testing: labs, imagine (see referral guidelines for specifics)

Reason for Referral (include Diagnosis and ICD code):

Referring Physician: _____ Phone: _____ Fax: _____