Official Use Only
Medical Record: _____

Medical Oncology Phone: (808) 932-3590 | Medical Oncology Fax: (808) 974-6864
Radiation Oncology Phone: (808) 932-3755 | Radiation Oncology Fax: (808) 932-3756

New Patient Referral Form

Date: _____

Patient Information:

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: ___

Referral to: ☐ **Medical Oncology** ☐ **Radiation Oncology**

Fax: 808-974-6864 **Fax: 808-932-3756**

Request:

☐ **STAT** – Provider to Provider call needed
For Radiation Oncology please dial (808) 932-3000 and press # to enter extension **1703**
For Medical Oncology, please dial (808) 932-3000 and press # to enter extensions **5718**

☐ **ROUTINE** – Processed and scheduled per routine protocol

Confirmation of patient's appointment date and time will be given upon receipt of all pertinent documents.

For Oncology Referral, please include the following:

- ☐ **History and Physical**
- ☐ **Pathology Reports (All pathology reports)**
- ☐ **Operative Reports (if any)**
- ☐ **Discharge Summary (if applicable)**
- ☐ **Demographics/ insurance**
- ☐ **Lab Reports**
- ☐ **Imaging (Diagnostic) Reports**
- ☐ **Previous Oncology Records (if treated elsewhere)**
- ☐ **Office Visit Notes (most recent)**

Reason for Referral (include Diagnosis and ICD code):

_____
_____
_____

Referring Physician: _____ **Phone:** _____ **Fax:** _____

Form: 7371-0202-21 10/6/21