

- Kristi Lopez, M.D.
- Jennifer Tamai, M.D.
- Carl Tadaki, M.D.



Reece Goo, PA-C
 Rozanne Schirmer, APRN
 Donita Valdez, APRN

Phone (808) 528-3606 Fax (808) 538-7850 Efax (808) 400-6927

Kuakini Medical Plaza
 321 N Kuakini Street, Ste 714
 Honolulu, HI 96817

Pearlridge Office Center
 98-211 Pali Momi Street, Ste 312
 Aiea, HI 96701

REFERRAL FORM

DATE: _____ **URGENT REQUEST** (Diagnosis): _____

Please complete this referral form & provide additional information below via FAX (808) 538-7850:

- Patient’s demographic sheet, insurance information
- Patient’s recent clinic notes, labs, imaging (if applicable)
- Previous EGD, Colonoscopy and pathology reports
- Completed HMO/Quest authorizations/referral forms (if required by insurance plan)

If approved, patients will be scheduled with the next available provider unless otherwise specified.

PATIENT INFORMATION

INSURANCE INFORMATION

Patient Name: _____
 Patient DOB: _____
 Primary phone # _____
 Alternate Phone # _____
 SSN: _____ - _____ - _____

Primary Insurance: _____
 Subscriber Number: _____
 Subscriber Name & DOB: _____
 Secondary Insurance: _____
 Subscriber Number: _____
 Subscriber Name & DOB: _____

DIAGNOSIS INFORMATION

Reason for referral/diagnosis: _____

Referring Provider: _____ Phone: _____ Fax: _____

Primary Care Provider: _____ Phone: _____ Fax: _____

(If different than referring)

Referring Provider Signature: _____