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REFERRAL FORM

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

☐ Pearl Ridge Office Center
98-211 Pali Momi Street, Ste 312
Aiea, HI 96701

Date: _____ ☐ **URGENT REQUEST** (Diagnosis):_____

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

- ☐ Patient's demographic sheet, insurance information
- ☐ Patient's recent clinic notes, labs
- ☐ Previous EGD, Colonoscopy and pathology reports
- ☐ Completed HMO authorizations/referral forms

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

PATIENT INFORMATION:

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

INSURANCE INFORMATION:

Primary Insurance: _____
Subscriber Number: _____
Subscriber Name/ DOB: _____

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

DIAGNOSIS INFORMATION

Reason for referral: _____

Referring Provider: _____ Phone: _____ Fax: _____

Primary Care Provider: _____ Phone: _____ Fax: _____
(If different than Referring)

Referring Provider Signature: _____