☐ KMC for Women & Children
☐ KMC at Pali Momi
☐ Women's Center

	PHONE	FAX
	983-8626	983-8710
	485-4222	485-4233
	535-7000	973-6537

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI MEDICAL CENTER FOR WOMEN & CHILDREN

IMAGING OUTPATIENT PROCEDURE REQUEST FORM

Instructions: Complete this form, sign it and fax it to the department (numbers above) or give to your patient to bring to their appointment.

Patient's Name: _____ Date of Service: ____ /____ / ____
Last First M.I.

Time of Exam: _____

Date of Birth: ____ /____ / ____

Insurance: _____ Home Phone: _____

Procedure: _____

History: _____
Personal or family medical history related to the procedure

Symptoms & Chief Complaint: _____
Personal or family medical history to include allergies related to the procedure

_____
Any specific signs, symptoms or complaints related to this procedure; not "rule-out" or "routine"

What questions do you want answered? _____

Date of Injury _____
Is this for Workmens Comp? _____

_____

Physician Signature: _____ _____
Required *Date*

Print Name: _____

Office Phone: _____ **Office Fax Number:** _____

Copy of Report To: _____

☐ Patient to return to my office ☐ Films and wet read ☐ Wet read only
☐ Films only ☐ Patient may leave ☐ Other _____

Record Decision Support Information?

-Decision Support Vendor: _____
-Decision Support Adherence: _____
-Decision Support Session ID: _____
-Decision Support Score: _____