HAWAI'I PACIFIC HEALTH | KAPI'OLANI MEDICAL CENTER FOR WOMEN & CHILDREN

Hawaii Community Genetics Referral Form

MR# (for office use): ______________________

This referral form must be completed by the patient's PCP's office if the patient has Quest or an HMO.

Date: ___________________________

☐Male ☐Female

Patient's Last Name ____________ First Name ____________ Middle Initial ____ Date of Birth ____

Ethnicity ____________ Primary Language Spoken At Home ____________ Marital Status ____________

Mailing Address ____________ City ____________ State ____ Zip Code ____

Home Number ____________ Cell Phone Number ____________ Work Number ____________

Primary Insurance ____________ Subscriber # ____________ Subscriber's Name ____________ Medical Code ____________

Secondary Insurance ____________ Subscriber # ____________ Subscriber's Name ____________ Medical Code ____________

Mother/Spouse Name ____________ Date of Birth ____________ Contact number ____________

Father/Spouse Name ____________ Date of Birth ____________ Contact number ____________

Referring Physician ____________ Contact/Fax # ____________ Contact person ____________

Primary Physician ____________ Contact/Fax # ____________ Contact person ____________

REASON FOR REFERAL

☐ Positive Newborn Screen for ______________________________ or ☐ Alpha Thalassemia (D56.0)

☐ Confirmed Congenital Hearing Loss (H91.90)

☐ Developmental concerns: Intellectual disability (F79) Autism (F84.0) Delayed milestones (R62.0) Language delay (F80.1)

☐ Growth concerns: Failure to thrive (R62.51) Asymmetry/hemihypertrophy (Q89.8) Short stature (R62.52) Overgrowth/Tall stature (E34.4) Skeletal dysplasia, NEC (Q78.9)

☐ Birth defects ______________________________

☐ Dysmorphic features (Q89.7) ______________________________

☐ Neurologic symptoms ______________________________

☐ Dermatologic: Abnormal skin pigmentation (L81.9) Ichthyosis/scaly skin (Q80.9) Café au lait macules (L81.3) Vascular birthmarks (D18.01)

☐ Patient has known/suspected chromosomal or genetic disorder ______________________________

☐ Family history of chromosomal or genetic disorder ______________________________

☐ Other ______________________________

Fax completed form to (808) 373-7599. Call us at (808) 373-7555 if you have any questions.