HAWAIʻI PACIFIC HEALTH | PALI MOMI MEDICAL CENTER

PALI MOMI PULMONOLOGY CLINIC
REFERRAL FORM

98-1079 Moanalua Road, Suite 570 • Aiea, Hawaiʻi 96701
Telephone 808-485-3085 • Fax 808-835-9899

Confirmed Patient Appointment: Date _____ Time _____

► PATIENT INFORMATION

Last Name _____ First Name _____

Birth Date (mm/dd/yyyy) _____/_____/_____ Home Phone_____

Cell Phone _____ Work Phone _____

Mailing Address _____

Is special accommodation required? Yes ___ No ___

Does patient use any assistive devices Yes ___ No ___

If yes, please indicate: Walker___ Cane___ Scooter___ Other, explain: _____

► REASON FOR REFERRAL

_____

Medical Diagnosis/ ICD-10 _____

Second Opinion? □ No □ Yes [Who was your most recent pulmonologist?] _____

► INSURANCE INFORMATION

Primary Insurance _____Subscriber _____ Subscriber # _____

Secondary Insurance _____Subscriber _____ Subscriber # _____

Insurance Pre-Authorization Number _____ Date Received _____

► REFERRING PHYSICIAN

Physician Name _____Phone _____

Physician Signature _____Fax _____

Contact Person _____Phone _____

Please send supporting documents with referral:

- Radiology Reports (chest images)
- Doctor's Notes (past 3 months)
- PFT Report(s)
- Medication List

Fax request and documents to 808-835-9899

NOTE: Appointments are only scheduled when all documents are received.
Patients must bring a picture ID and insurance card(s).
We do not accept Worker's Comp and No-Fault Insurances.