



## PALI MOMI OUTPATIENT SURGICAL CLINIC REFERRAL FORM

98-1079 Moanalua Road, Suite 630 • Aiea, HI 96701

Telephone (808) 485-5414 • Fax (808) 485-3022

\_\_\_\_\_  
Preferred Provider / Specialty

Patient is confirmed for: Date \_\_\_\_\_ Time \_\_\_\_\_ with Dr. \_\_\_\_\_

### ► PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth (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 surgeon?] \_\_\_\_\_

Previous surgery \_\_\_\_\_

### ► INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

### ► REFERRING PHYSICIAN

Physician Name: (please print name) \_\_\_\_\_ Phone: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Please send supporting documents with referral:

- Most recent H & P
- Radiology reports
- Doctor's notes (past 3 months)
- Lab & Pathology reports
- Medication list

**Fax request and documents to: (808) 485-3022**

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 Insurance.