HAWAIʻI PACIFIC HEALTH | PALI MOMI MEDICAL CENTER

PALI MOMI BONE AND JOINT CLINIC REFERRAL FORM

98-1079 Moanalua Road, Suite 300 • Aiea, Hawaiʻi 96701
Telephone 808-485-4120 • Fax 808-485-3090

____
Preferred Provider / Specialty

Confirmed Patient Appointment: Date ___________ Time _____________ with Dr.________________

► 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 orthopedist?] ________________________

Previous surgery ____

► INSURANCE INFORMATION

Primary Insurance _______________Subscriber _______________ Subscriber # _______________

Secondary Insurance _____________Subscriber _______________ Subscriber # _______________

Is this injury worker's compensation related? ☐ Yes ☐ No

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
- Doctor's Notes (past 3 months)
- Lab & Pathology Reports
- Medication List

Fax request and documents to 808-485-3090

NOTE: Appointments are only scheduled when all documents are received.
Patients must bring a picture ID and insurance card(s).