

PALI MOMI PLASTIC SURGERY CLINIC - REFERRAL FORM

98-1079 Moanalua Road, Suite 640 • Aiea, HI 96701

Telephone 808-485-4352 • Fax 808-485-4377

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 808-485-4377

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.