HAWAIʻI NEPHROLOGISTS

NEW PATIENT REFERRAL FORM

Patient's name: _____ DOB: _____ SEX: ☐ M ☐ F

Patient's phone: _____ Alt phone: _____

Referring physician: _____ PCP (if different): _____

Reason for consult: _____

_____

_____

_____

Patient's insurance carrier: ☐ Medicare ☐ QuestMedicaid ☐ Private ☐ VA ☐ HMSA

☐ Ohana Health Plan ☐ United Healthcare ☐ AlohaCare ☐ Other _____

Policy number: _____

Referral office location: ☐ Hilo ☐ Kona ☐ Oahu Urgent: YES ☐ NO ☐

Please include the following documentation with your referral:

☐ Demographics/insurance info ☐ Current H&P ☐ Physician's visit notes

☐ Recent lab report ☐ Active medication list ☐ Radiology report

Staff contact name: _____ Date: _____

Phone: _____ Fax: _____

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