Hawai'i Infectious Disease Associates

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New Patient Referral Form

Name of Patient:

____, ___________________

First Name Middle Initial Last Name Date of Birth

Referred By:____

Reason for referral with ICD-10:

____

Primary Contact: (_______) ____________ - ____________

Emergency Contact: (_______) ____________ - ____________ Relationship:_____________

Email: ____

Primary Insurance: ______________________ MEM No:_______________________________

Subscriber: ____________________________ Relationship: ____________________________

Secondary Insurance: ____________________ MEM No: ______________________________

Subscriber: ____________________________ Relationship: ____________________________

Please fax over the following:

- ☐ Last Office Visits Notes
- ☐ Most recent labs
- ☐ Medication List
- ☐ Photo ID and Insurance Card ID

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Reviewed By:_______________________Scheduler:_____________________, Date___________