CANCER CENTER
THE QUEEN'S MEDICAL CENTER

1301 Punchbowl Street
Honolulu, Hawaii 96813
TELEPHONE: (808) 691-8777 FACSIMILE: (808) 691-8780

New Consultation Referral Form

DIAGNOSIS/INFORMATION FOR CONSULTATION REQUEST

Patient Name: _____ **Date of Birth:**____/____/_____ **Today's Date:**_____/_____/_____

Diagnosis:_____ **ICD-10:**_____

Reason for Consultation:_____

Referral Status: ☐ New Patient ☐ Second Opinion ☐ Transfer of Care

Urgency: ☐ Urgent ☐ Within 2 weeks ☐ Next available appointment

REQUIRED: **ALL Medical Oncology** referrals **MUST** have COVID-19 negative test within 5-7 days prior to appointment

COVID-19 Test: ☐ Yes ☐No ☐ Positive ☐ Negative Date of Result: _____/_____/_____

Medical Oncology:
- ☐ Dr. Jared Acoba
- ☐ Dr. Clayton Chong
- ☐ Dr. Carl Higuchi
- ☐ Dr. Kaye Kawahara
- ☐ Dr. Gordon Nakano
- ☐ Dr. Ryon Nakasone
- ☐ Dr. Kenneth Sumida
- ☐ Dr. Yoshihito D. Saito
- ☐ Dr. Nicolas Villanueva

Surgical Oncology:
- ☐ **General:** Dr. Shane Morita

Thoracic Oncology:
- ☐ Dr. Paul Morris
- ☐ Dr. Ayman Abdul-Ghani

Gynecologic Oncology:
- ☐ Dr. Robert Kim
- ☐ Dr. Keith Terada

Neurosurgeon:
- ☐ Dr. Daniel Donovan

Support Services:

Endocrinology
- ☐ Dr. Michael Bornemann
- ☐Dr. Harlan Meyer

- ☐ **High Risk Breast Clinic**: APRN
- ☐ **GI 2ND Opinion**: Dr. Randall Holcombe
- ☐ **Behavioral Health:** Dr. Barry Carlton

Previously/Currently Seeing a Hematologist/Oncologist: ☐ No ☐ Yes Name:_____

Treatment Undergone: _____ **Last Treatment Date**:_____/_____/_____

*****THE FOLLOWING DOCUMENTS ARE REQUIRED IN ORDER TO PROCESS THIS CONSULTATION REQUEST:**

☐ Three (3) Progress Notes ☐ Imaging Reports ☐ Pathology Reports ☐ Three (3) Recent Lab Results ☐ Op/Procedure Reports

To ensure your patient is scheduled with the appropriate service and to avoid delays, please include ALL applicable documents along with this form. Appointments will not be scheduled until all pertinent correspondence is received.

Thank you for choosing The Queen's Cancer Center.

REFERRING PROVIDER INFORMATION

Referring Provider: _____ Referring Provider Signature: _____

Contact Person: _____ Office Number:_____ Fax Number:_____

Referral Letter/Authorization: ☐ Yes Date obtained: _____/_____/_____ ☐ Not Required

PATIENT INUSRANCE/DEMOGRAPHIC INFORMATION

Primary Insurance:_____ Subscriber Number: _____

Secondary Insurance:_____ Subscriber Number: _____

Home Address:_____ City: _____ State:_____ Zip code:_____

Contact Number: (_____)_____ Alternate Contact Number: (_____)_____

Primary Language:_____ **Interpreter Required:** ☐ No ☐ Yes

For QCC Office Use Only: Date Referral Received & Logged:_____ Received by: _____ Initial:_____

MRN: _____ ☐ Outer Island RN Navigator: _____ MA/PPA: _____ *Revised 2020_09 wts*