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 (require all records)
Urgency: ☐ Urgent ☐ Within 2 weeks ☐ Next available appointment

Medical Oncology:
- ☐ Dr. Jared Acoba
- ☐ Dr. Clayton Chong
- ☐ Dr. Carl Higuchi
- ☐ Dr. Kaye Kawahara
- ☐ Dr. Gordon Nakano
- ☐ Dr. Ryon Nakasone
- ☐ Dr. Kenneth Sumida
- ☐ Dr. David Y. 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

Orthopedic Oncology:
- ☐ Dr. Sean Kelly

Support Services:

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

☐ **High Risk Hereditary Clinic**: Terri Imada, APRN-Rx
☐ **Behavioral Health:** Dr. Barry Carlton

Previously/Currently seeing a Hematologist/Oncologist or Radiation Oncologist? ☐ No ☐ Yes, Location:_____
Provider Name(s):_____ **Treatment Plan:**_____
_____ **Last Treatment Date**:_____/_____/_____
Records Included: ☐ Chemotherapy Treatment Plan & Notes ☐ Radiation Treatment Plan & Notes
Clinical Trial: ☐ No ☐ Yes, Name of Study:_____ Clinical Trial Liaison: _____

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

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

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:_____

PCP 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 2021_04 wts*