THE QUEEN'S MEDICAL CENTER

SPORTS MEDICINE
Physicians Office Building 3 ▪ 550 South Beretania Street, Suite 703 ▪ Honolulu, HI 96813
Ph: 808-691-4449 ▪ Fax: 808-691-4015 ▪ www.queens.org

REFERRAL FORM

Patient's Name _____ **DOB** _____

Address _____

Parent's Name (if patient is a minor) _____ **DOB** _____

Home Phone _____ **Cell Phone** _____

Insurance _____ **Subscriber ID#** _____

Diagnosis _____
_____

COMMENTS AND SPECIAL CONCERNS
_____
_____
_____
_____

Along with this referral form, please attach the following:

- Referring provider progress notes
- X-ray / MRI / CT reports
- Patient's demographic Face Sheet
- Any related diagnostic lab reports
- Insurance referrals if required *(ex: HMSA Quest, Alohacare Quest, HMA HMO, Ohanacare Qexa, UHC Qexa, Tricare)*

Please have your patient bring all related radiology films/CDs, identification cards and insurance cards to the appointment. All minors must be accompanied by a parent or legal guardian to the appointment

Referring Physician _____ **Date** _____

Address _____

Phone _____ **Fax** _____

*****PLEASE FAX THIS FORM AND ATTACHMENTS TO 808-691-4015*****