THE QUEEN'S MEDICAL CENTER WEST O'AHU

PROVIDER REFERRAL REQUEST FORM

REFERRING TO

Specialty:

☐Cardiology (Ph: 691-3340 | Fax: 691-3345)
☐Diabetes (Ph: 691-3370 | Fax: 691-3360) **SEE SECTION E**
☐Gastroenterology (Ph: 691-3150 | Fax: 691-3151)
☐General Surgery (Ph: 691-3150 | Fax: 691-3151)
☐Neurology (Ph: 691-3340 | Fax: 691-3345)
☐Wound Care (Ph: 691-3788 | Fax: 691-3785) **SEE SECTION B**
☐Pain Management (Ph: 691-5390 | Fax: 691-5389)
☐Pulmonology (Ph: 691-3766 | Fax: 691-3760) **SEE SECTION A**
☐Sleep Lab (Ph: 691-3799 | Fax: 691-3760) **SEE SECTION D**
☐Sports Medicine (Ph: 691-4449 | Fax: 691-4015)
☐West Cancer/Infusion (Ph: 691-3777, 691-3790) **SEE SECTION C**
☐Other: _____

Referring Provider's Name (Printed): _____ **Phone/Fax #:**

Referring Provider's Signature: _____

Please Schedule (select one):

☐ Urgent-- Referring physician called _____

☐ Routine Appointment with Specific Physician listed: _____ _____

☐ First Available with any Physician

PATIENT INFORMATION

Patient Full Legal Name: _____ DOB: _____

Phone Number: _____ E-Mail Address: _____

If patient is under 18 years old – Parent Contact Name & Number(s):

GENERAL INFORMATION

Reason for Referral (*Clinical Question*):

Comments/Considerations Related to Clinical Question: *Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes*

Patient aware of reason for referral? ☐ Yes ☐ No: **Explain:** _____

Interpreter Services Needed? ☐ Yes ☐ No: **Language:** _____

Please complete this referral and fax with copies of:

- Patient's contact & insurance information
- Last two (2) office visit notes
- Prior authorizations (if applicable)
- Any additional clinical information (if needed)

Physician's Name **(please print)**: _____ NPI: _____

Physician's Signature: _____ Date: _____

Physician Phone Number:_____ Physician Fax Number: _____

Section A: Pulmonology Clinic - Ph: (808) 691-3766 Fax: (808) 691-3760

☐ Complete Pulmonary Evaluation ☐ COPD/Asthma ☐ Sleep Complications ☐ Other

Please provide all current pertinent test results (i.e. Chest CT Scan, Chest X-Ray, PFT, Prior Sleep Study, etc.)

Section B: Wound Center – Ph: (808) 691-3788 Fax: (808) 691-3785

☐ # of wounds _____
☐ Location of wound _____
☐ Is patient consulting with a vascular surgeon?
☐ If yes, is this referral approved by the vascular surgeon? Yes/No
☐ Is the wound on a surgical site (i.e. amputation stump?) Yes/No
☐ Does the patient have a history of the following? ❑ MRSA ❑ VRE ❑ ESBL ❑ C.DIFF

If the injury is covered by a Worker's Compensation or No-Fault claim, please provide the following information:

Insurance Carrier: Body part injured: Date of Injury:
Claim #: Adjustor Name: Adjustor Phone #

Section C: Cancer-Infusion Center – Ph: (808) 691-3777 Fax: (808) 691-3790

TYPE: ❑ New Patient ❑ Urgent ❑ Within the week ❑ Next Available ❑ Transfer of Care ❑ Second Opinion

Please provide all current pertinent H&P, Labs and Prior-Authorization.

Please list below what services you are requesting from our clinic:

Section D: Sleep Center – Ph: (808) 691-3799 Fax: (808) 691-3760

Height: _____ Weight: _____

Please check all appropriate items:

Pulmonary Disease: ❑ Asthma ❑ Bronchitis ❑ COPD ❑ CO2 Retention ❑ Hypoxemia ❑ Other:_____

Oxygen Use? ❑ Yes ❑ No ❑LPM _____ CPAP/BiPAP/ASV use? ❑ No ❑ Yes If "Yes" pressure___cmH2O

Follow-Up study? ❑ Yes ❑ No Reason for Follow-Up Study:_____

Sleep History (Check All Appropriate Items):

Major Criteria – At least one (1) required

❑ Documented Unexplained Sleep-Related Cardiac Arrhythmias
❑ Documented Unexplained Sleep-Related Oxygen Desaturation
❑ Observed Sleep-Related Apnea or Gasping and Choking
❑ Habitual/Disruptive Snoring
❑ Documented Sleep Apnea Syndrome
❑ Unexplained Pathological Daytime Sleepiness/Non-Restorative Sleep

Minor Criteria: (Two (2) or more required, if only 1 major criteria indicated)

❑ Neuromuscular Disease
❑ Cerebrovascular Accident
❑ Cor Pulmonale (unexplained)
❑ Morning headaches
❑ Essential Hypertension
❑ Obesity
❑ Decreased Cognitive Function
❑ Polycythemia
❑ Memory Impairment
❑ Hypothyroidism (untreated)
❑ Pulmonary Hypertension

HEENT Abnormalities

❑ Craniofacial Abnormality (Down's Syndrome, Acromegaly)
❑ Enlarged Tonsils/Adenoids
❑ Long Soft Palate
❑ Other: _____
❑ Macroglossia
❑ Micrognathia
❑ Nasal Obstruction
❑ Narrow High-Arched Palate
❑ Narcolepsy
❑ Sleep-Related Myoclonus

THE QUEEN'S MEDICAL CENTER WEST O'AHU

Diabetes Management and Education Center - West O`ahu
Order Referral Form

Phone: 808-691-3370 Fax: 808-691-3360

If you have CareLink (Epic), please fill out electronic order instead.
NOTE: This form complies with MEDICARE guidelines.

Patient's Name:_____ **D.O.B.** _____ **Male☐Female☐**

Patient's Contact: Home:_____ **Cell:**_____ **Work:**_____

1. **Reason(s) for referral:**
   ☐New/Recent Diagnosis ☐Review/Reinforcement ☐Recurrent Hyperglycemia or Hypoglycemia
   ☐Lacks previous DSME ☐Medication Management
   ☐Dietary/Nutrition:(specify)_____
   ☐Other:_____

2. **Diagnosis:** (**check all that apply**)
   ☐ **E 11.9** Diabetes Type 2 controlled
   ☐ **E 11.65** Diabetes Type 2 uncontrolled
   ☐ **E 10.9** Diabetes Type 1 controlled
   ☐ **E 10.65** Diabetes Type 1 uncontrolled
   ☐ **E 11.29** Type 2 DM w/ other kidney complications
   ☐ **E 11.22, N 18.**___ DM Type 2 w/ diabetic CKD,Stage___
   ☐ **E 10.22, N 18.**___ DM Type 1 w/ diabetic CKD, Stage___
   ☐ **R73.09** Pre-Diabetes

   ☐ **N 18.**___ Chronic Renal Failure-Stage_____
   ☐ **N 18.9** Chronic Renal Failure, unspecified
   ☐ **Z 94.0** S/P Kidney Transplant (<36 months)
   ☐ **E 78.5** Hyperlipidemia, unspecified
   ☐ **I 10** Hypertension, essential (primary)
   ☐ **E 66.9** Obesity, unspecified
   ☐ _____ **Other:**_____

3. **Service(s) Requested:**
   ☐ **Diabetes Self Management Education (DSME)**
   ☐ **GROUP Diabetes Self Mangement Education (DSME)**
   ☐ **INDIVIDUAL Diabetes Self Management Education (DSME)**
   Special need(s) supporting referral for Individual Education *(Required by Medicare):*
   ☐Impaired Vision ☐Impaired Hearing ☐Impaired mobility/Dexterity ☐Language Barriers
   ☐Learning Disability ☐Impaired Mental Status/Cognition ☐13 to 18 years of age ☐Other: _____

   Diabetes Self-Management Education (DSME) Content
   Includes Individual Assessment and **ALL TOPICS** listed below for a **total of 10 hours** unless otherwise indicated
   ☐ **ALL TOPICS** (recommended option, comprehensive DSME)
   ☐_____hours; please specify topics requested:
   ☐Disease Process
   ☐Nutrition
   ☐Exercise
   ☐Medication
   ☐SMBG/Monitoring
   ☐Stress Management/Adjustment & Support
   ☐Risk Reduction
   ☐Problem Solving
   ☐Goal Setting

   ☐ **Annual/Post Program Follow Up DSME (patient previously attended DSME)**
   Note: Medicare covers 10 hours initial DSME and 2 hours follow up each calendar year.

   ☐ **MEDICAL NUTRITION THERAPY (MNT) (DIETITIAN)**
   Note: Medicare allows 3 hours in the first year then 2 hours follow up each calendar year. Medicare covers DM/CKD/CRF/Renal Transplant Only.

   ☐ **Diabetes Medication Management/ Insulin Dose Titration and Adjustment (APRN)**
   ☐ **Blood Glucose Meter Training**
   ☐ **Insulin and Non-Insulin Injectables Instruction** ***(Please FAX copy of Rx)***

4. **Self Monitoring Blood Glucose Goals (SMBG and A1c):**
   ADA SMBG and A1c goals will be used unless otherwise specified (Plasma: Fasting= 80-130; PP <180 1-2 hr; A1c= 6.5-7.0%)
   If not using ADA goals, please indicate the patient's goals:
   Fasting / Pre-prandial:_____**mg/dL** **1-2 Hr Post-prandial:**_____**mg/dL** **HS:**_____**mg/dL** **A1c:**_____

5. **Exercise Recommendation:**
   ☐No Limitations ☐Limitations, as follows: _____

IF YOU ARE NOT ON CARELINK, PLEASE FAX REFERRAL TO 808-691-3360 ALONG WITH THE FOLLOWING:
☑ **Copy of the latest original lab values: • Fasting Glucose • HbA1c • Lipid Profile • Chemistry • Urine Micro-albumin**
☑ **Patient's current H&P and recent Progress Notes pertinent to diagnosis**
☑ **List of patient's medications prescribed and/or taking, meter type and test supplies being used**
☑ **Copy of Patient's insurance card(s)**

I certify that the education is medically appropriate and needed for the above patient.

Physician's Name **(please print)**: _____NPI: _____

If this is a **Medicare** Patient, Referring Physician must be a Medicare Provider. Are you a Medicare Provider? ☐**Yes** ☐**No**

Physician's Signature:_____Date: _____

Physician Phone Number:_____ Physician Fax Number:_____

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