THE QUEEN'S MEDICAL CENTER WEST O'AHU

PROVIDER REFERRAL FORM

Specialty

- ☐ Cardiology (Ph: 691-3340 | Fax: 691-3345) **SEE SECTION E**
- ☐ Diabetes Management (Ph: 691-3370 | Fax: 691-3360) **SEE SECTION D**
- ☐ Ear, Nose, Throat / Audiology (Ph. 691-3352 | Fax: 691-3355)
- ☐ Gastroenterology (Ph: 691-3150 | Fax: 691-3151)
- ☐ Neurology (Ph: 691-3135 | Fax: 691-3347) **SEE SECTION F**
- ☐ Orthopedic Surgery (Ph: 691-3520 | Fax: 691-3815)
- ☐ Pain Management (Ph: 691-5390 | Fax: 691-5389)
- ☐ Pulmonology (Ph: 691-3766 | Fax: 691-3760)
- ☐ Pulmonary Function Test (Ph: 691-3766 | Fax: 691-3760)
- ☐ Sleep Lab (Ph: 691-3799 | Fax: 691-3760) **SEE SECTION C**
- ☐ Urology (Ph: 691-3890 | Fax: 691-3891)
- ☐ West Cancer / Infusion (Ph: 691-3777 | Fax: 691-3790) **SEE SECTION B**
- ☐ Wound Care (Ph: 691-3788 | Fax: 691-3785) **SEE SECTION A**

Referral Type

- ☐ Urgent – Referring physician called _____
- ☐ Routine appointment with specific physician listed: _____
- ☐ First available with any physician

Patient Information

Patient Full Legal Name		Date of Birth (mm-dd-yyyy)
Contact Phone Number(s)		Email Address
Parent Name, if minor		
Patient Insurance Information	Does the patient need an interpreter? ☐ Yes ☐ No	If yes, what language?
Is Patient Aware of Referral? ☐ Yes ☐ No Explain:		

Referring Physician or Provider Information

Referring Provider Name (print)	NPI
Office Phone	Office Fax
Referring Provider Signature	Date

Appointment Request

Clinical Reason for Referral (please also submit any pertinent medical records)

Please complete this referral and fax with copies of the following:

- ☐ Patient's contact and insurance information
- ☐ Last two (2) office visit notes to include medication list, problem list, and allergies
- ☐ Imaging reports
- ☐ Recent labs
- ☐ Prior authorization or insurance referral, if applicable

REV. 2/9/21

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

Number of wounds:

Location of wound(s):	Is wound on a surgical site (e.g., amputation stump)? ☐ Yes ☐ No
Is patient consulting with a vascular surgeon? ☐ Yes ☐ No	If yes, is this referral approved by the vascular surgeon? ☐ Yes ☐ No

Does patient have a history with any the following:
☐ MRSA ☐ VRE ☐ ESBL ☐ C.DIFF

Does your patient identify as Native Hawaiian *and* require transportation support? ☐ Yes ☐ No
By checking "yes", patient may be eligible for transportation navigation through the Nā Pua Kaiona program. Referral will be reviewed and initiated by Navigator.

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

- Insurance carrier:
- Claim #:
- Body part injured:
- Date of injury:
- Adjustor name:
- Adjustor phone number:

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

NOTE: Providers referring to Infusion Services must be credentialed with The Queen's Medical Center.

Select one (1) department: ☐ Cancer Center ☐ Infusion Services

Cancer Center (check all that apply): ☐ New Patient ☐ Urgent ☐ Transfer of Care ☐ Second Opinion

Infusion Services (check all that apply): ☐ Urgent ☐ Within the Week ☐ Next Available

For either service, please provide all current pertinent H&P, labs, and prior-authorization.

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

Height	Weight

Consults and Tests – select one (1) of the following:

☐ **Sleep Consultation and Management:** Sleep Specialist to manage, test, treat, and follow-up.
☐ **Sleep Testing Only:** Referring physician will manage treatment and follow-up.
(*Medical Director will determine appropriate test : Diagnostic full-night polysomnography, Split-night polysomnography, CPAP evaluation, Home Sleep Test (HST), MSLT, MWT)*

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 is _____ cmH2O
Follow-up study? ☐ Yes ☐ No
If yes, please state reason for follow-up study:

Patient 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 was 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 abnormal (Down's Syndrome, Acromegaly)
☐ Enlarged tonsils/adenoids
☐ Long soft palate
☐ Macroglossia
☐ Micrognathia
☐ Nasal obstruction
☐ Narrow high-arched palate
☐ Narcolepsy
☐ Sleep-related myoclonus
☐ Other: _____

Section D: Diabetes Management & Education Center – Ph: (808) 691-3370 Fax: (808) 691-3360

Reason(s) for Referral:

☐ New / Recent Diagnosis ☐ Review / Reinforcement ☐ Recurrent Hyperglycemia or Hypoglycemia
☐ Lacks Previous DSME ☐ Medication Management
☐ Dietary / Nutrition: _____
☐ Other: _____

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 2 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
☐ Other: _____

Service(s) Requested:

☐ Diabetes Self-Management Education Program (DSME)
☐ GROUP Diabetes Self-Management Education Program (DSME)
☐ INDIVIDUAL Diabetes Self-Management Education Program (DSME)
Special need(s) supporting referral for Individual Education (required by Medicare):
☐ Impaired Vision ☐ Impaired Hearing ☐ Language Barrier
☐ Learning Disability ☐ Impaired Mental Status / Cognition ☐ 13 to 18 years of age
☐ Other: _____

Diabetes Self-Management Education (DSME): Includes individual assessment and ALL TOPICS below (10 hours), unless otherwise indicated:

☐ **ALL TOPICS** – recommended, comprehensive DSME, or
☐ _____ hours. Please check all topics requested: ☐ Disease Process ☐ Exercise ☐ Nutrition ☐ Medication ☐ SMBG / Monitoring
☐ 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) with Dietician
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**

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 hours; A1c = 6.5 – 7.0%)
If not using ADA goals, please indicate the patient's goals:

Fasting / pre-prandial: _____mg / dL **1 – 2 hour post-prandial: _____mg / dL** **HS: _____mg / d** **A1c: _____**

If you are **NOT** on CARE*Link, please **fax** referral to 808-691-3360 along with the following:

- Copy of the latest original lab values – fasting glucose, HcA1c, lipid profile, chemistry, and 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 insurance card(s)

I certify that the education is medically appropriate and needed for the above patient.
If this is a **Medicare** patient, referring physician must be a Medicare provider. Are you a Medicare provider? ☐ Yes ☐ No

Referring Provider Name (print)	NPI
Office Phone	Office Fax
Referring Provider Signature	Date

Section E: Cardiology – Ph: (808) 691-3340 Fax: (808) 691-3345

NOTE: We are not accepting Worker's Comp or No-Fault Insurance at this time.

Does patient have a Pacemaker or Implantable Cardioverter Defibrillator (ICD)?
☐ Yes ☐ No
If "Yes": Name of Device Company: _____ Date of Last Check: _____

Has this patient ever been seen by a previous Cardiologist?
☐ Yes ☐ No
If "Yes": please send ALL notes from the previous provider or have patient ask their previous provider to fax their records to us at (808) 691-3345.
Reason for changing Cardiologists (if known): _____

Is this referral for a second opinion?
☐ Yes ☐ No

Has patient had cardiac testing done?
☐ Yes ☐ No
If "Yes": please send cardiac testing report(s) if they were not completed at a Queen's Medical Center facility.

Section F: Neurology – Ph: (808) 691-3135 Fax: (808) 691-3347

NOTE: We are not accepting Worker's Comp or No-Fault Insurance at this time.

Is this referral related to an accident or injury? ☐ Yes ☐ No
If "Yes", please explain the accident or injury: _____

Has this patient ever been seen by a previous Neurologist? ☐ Yes ☐ No
If "Yes", please send ALL notes from the previous provider or have patient ask their previous provider to fax their records to us at (808) 691-3347.

Is this referral for a second opinion? ☐ Yes ☐ No

Has this patient had imaging studies related to the reason for this referral? ☐ Yes ☐ No
If "Yes", please send imaging report(s) if they were not completed at a Queen's Medical Center facility.

Please also complete the below section if referring for Electromyogram and Nerve Conduction Studies (EMG / NCS)

1. **Does patient also need a neuromuscular consultation?** ☐ Yes ☐ No (If this is the first visit with Dr. Miles, the EMG may be converted to a consult)
2. **Symptoms:** ☐ Numbness ☐ Paresthesia ☐ Weakness ☐ Pain ☐ Other: _____
3. **Location of symptoms:** ☐ RUE ☐ LUE ☐ RLE ☐ LLE ☐ Right Face ☐ Left Face ☐ Generalized ☐ Other: _____
4. **Working diagnosis:**
   - ☐ Brachial Plexopathy
   - ☐ Critical Illness Myopathy (CIM) and Neuropathy
   - ☐ Myasthenia Gravis (MG)
   - ☐ Phrenic Neuropathy
   - ☐ Carpal Tunnel Syndrome
   - ☐ Guillain-Barré Syndrome
   - ☐ Myopathy
   - ☐ Ulnar Mononeuropathy
   - ☐ Cervical Radiculopathy
   - ☐ Lumbosacral Radiculopathy
   - ☐ Peripheral Polyneuropathy
   - ☐ Other: _____
   - ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
   - ☐ Motor Neuron Disease (MND) / ALS
5. **Is this patient on a blood thinner**? ☐ Yes ☐ No
   If "Yes", please indicate blood thinner :
   - ☐ Apixaban (Eliquis)
   - ☐ Clopidogrel (Plavix)
   - ☐ Enoxaparin (Lovenox)
   - ☐ Rivaroxaban (Xarelto)
   - ☐ Other: _____
   - ☐ Aspirin
   - ☐ Dabigatran (Pradaxa)
   - ☐ Fondaparinux (Atrixtra)
   - ☐ Warfarin (Coumadin)
6. **Is patient on Mestinon (Pyridostigmine)?** ☐ Yes ☐ No (*Pyridostigmine should be held on the day of the exam)*
7. **Does patient have a pacemaker or other implanted stimulator?** ☐ Yes ☐ No
8. **Does patient have a central line or PICC line?** ☐ Yes ☐ No
9. **Has the patient ever had botulinum toxin injections?** ☐ Yes ☐ No
10. **Has the patient ever had spine surgery?** ☐ Yes ☐ No
    If "Yes", please check affected area: ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbosacral Spine
11. **Special instructions for the Electromyographer:** _____

Please note: Due to the weight limit of our EMG / NCS equipment, we are not able to accommodate patients heavier than 300 lbs.
At the time of the EMG+NCS appointment, the patient's skin should be clean without any lotions, oils, or creams. No other special preparation is required.
If the patient is on Mestinon (Pyridostigmine), they should not take it the day of the test. The patient should take all their other medications as prescribed.
For patients on Warfarin (Coumadin), a recent (within 1 week) INR is required. Please be sure to indicate if the patient has a pacemaker or stimulator.
Patient should allow at least 2 hours for the study. There are no after effects and the patient may return to their usual activities immediately upon leaving the clinic.