QUEEN'S CANCER CENTERS

"We care for you. We care for your family.
We care for your community."

# 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 ☐ Re-establish care

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

**Medical Oncology:**

☐ Dr. Jared Acoba
☐ Dr. Shaun Donegan
☐ Dr. Matthew Ebia
☐ Dr. Carl Higuchi
☐ Dr. Jodi Kagihara
☐ Dr. Kaye Kawahara
☐ Dr. Brandon Kobayashi
☐ Dr. Ryon Nakasone
☐ Dr. Yoshihito David Saito
☐ Dr. Kenneth Sumida
☐ Dr. Nicolas Villanueva
☐ Dr. Gene Yoshikawa
☐ First available/No preference

**Location Preference:**

☐ **Queen's POB 1** - 1380 Lusitana St., Suite 405/608
Ph: 808-686-4222 | Fax: 808-686-4223

☐ **Kuakini** - 321 N. Kuakini St., Suite 402
Ph: 808-686-4244 | Fax: 808-686-2137

☐ **Queen's West** - 91-2135 Fort Weaver Rd., Suite B120
Ph: 808-691-3035 | Fax: 808-691-3823

Previously/Currently seeing a Hematologist/Oncologist or Radiation Oncologist? ☐ No ☐ Yes, Location: _____

Provider Names(s): _____

PCP: _____ Office Number: _____ Fax Number: _____

**Clinical Trial:** ☐ No ☐ Yes, Name of Study: _____ Clinical Trial Liaison: _____

*****TO EXPEDITE YOUR CONSULTATION REQUEST, THE FOLLOWING DOCUMENTS ARE REQUIRED:**

☐ Copy of ID & Insurance cards ☐ Last three (3) Progress notes ☐ Recent H&P ☐ Pathology Reports ☐ Three (3) months Lab Results ☐ Imaging ☐ Op/Procedure note ☐ Chemotherapy Treatment Plan & Notes ☐ Radiation Treatment Plan & Notes ☐ Insurance authorization (see below)

***To ensure your patient is scheduled with the appropriate service and to avoid delays, please include ALL applicable documents related to patient's diagnosis along with this form. Appointments will NOT be scheduled until all pertinent correspondence is recieved. Thank you for choosing the Queen's Cancer Center.***

## *REFERRING PROVIDER INFORMATION*

Referring Provider: _____ Provider Specialty: _____

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

## *PATIENT INSURANCE/DEMOGRAPHIC INFORMATION*

Primary Insurance: _____ Subscriber Number: _____

Secondary Insurance: _____ Subscriber Number: _____

HMO Referral/Insurance Authorization: ☐ Yes Date obtained: ___/___/____

☐ **Not Required** Name of Ins. Rep. you spoke to: _____ Date: _____

*****Please attach approval letter for patients with VA, TRICARE West Prime, Ohana SMG, and Any HMO plan*****

Home Address: _____City: _____ State: _____ Zip code: _____

Mailing Address: _____ ☐ Same as above

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

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

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

MRN: _____ ☐ Outer Island RN Navigator: _____ MA/PPA: _____ Revised 2026_09