Pulmonary Critical Care and Sleep Medicine Referral

1329 Lusitana Street Suite 107
Phone: 808-691-5252
Fax: 808-691-5250

REASON FOR REFERRAL:

□General Pulmonary (COPD, Asthma, SOB, cough, etc.) □Pulmonary Hypertension
□Pulmonary Fibrosis/Interstitial Lung Disease □Pleural Effusion

Patient will be assigned to the appropriate MD expertise pertaining to the referral

CHRISTOPHER FIACK, M.D.	KAORI ARNONE, APRN
STEPHANIE GUO, M.D.	
BRENT MATSUDA, M.D	
GEHAN DEVENDRA, M.D.	
JORDAN LEE, M.D.	
BRENT TATSUNO, M.D.	
THOMAS WONG, M.D.	

→Send corresponding documentation to support your reason for the referral
→**INCOMPLETE REFERRALS** will be returned to referring physician office if appropriate medical records are not received. **Records will be destroyed within 2 months if no response from the referring physician and another referral will need to be sent.**

Patient Name: _____ **DOB:** _____ **□MALE □FEMALE**
Best Contact Number: _____ **Insurance:** _____
Interpreter Required for this patient: **□YES □NO Language:** _____
Referring Diagnosis: _____

Referring Provider Name: _____ **Office Phone:** _____
Contact Name: _____ **Fax Number:** _____

Please attach the following records to referral as appropriate to referred diagnosis:

	Demographics		Echocardiogram/Right Heart Cath
	Insurance Card(s)/Authorization		Complete Pulmonary Function Test
	Most Recent Progress Notes		
	Chest X-Ray/CT Images and reports		
	PET scan Images and reports		
	Previous Pulmonologist Notes		

Comments: