QUEEN'S RHEUMATOLOGY CLINIC

QUEEN'S UNIVERSITY MEDICAL GROUP

Referral Form

Thank you for entrusting Queen's with your patient's care.
Please complete this form and fax it to the number below.
Appointments will not be scheduled until all pertinent records are received.

Queen's Rheumatology Clinic
Physicians Office Building 3, Suite 202
550 S. Beretania St., Honolulu, HI 96813
Phone: 808-691-8526, Fax: 808-691-5313

Patient Information

Patient Name:_____ Gender: ☐ Male ☐ Female ☐ Other

Date of Birth: _____ MRN/SSN:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

Preferred Language: _____

Primary Insurance_ _____ Authorization #_____

Secondary Insurance_____ Authorization #_____

Referral Information

☐ Schedule with First Available ☐ Requested Provider _____

Diagnosis and Associated ICD-10 Code(s):_____

Reason for Referral:_____

Fax This Form with Copies Below (As Applicable)

☐ Demographic Sheet / ID / Insurance
☐ Insurance Pre-Certification / Authorization
☐ Last (2) Office Visit Notes
☐ Pertinent Imaging Reports (XR, US, CT, MRI)
☐ Pertinent Labs & Pathology
☐ Current Medication List

Referring Physician Printed Name:_____

Phone:_____ Fax:_ _____ Date: _____

Primary Care Physician Name:_____ Date: _____