THE QUEEN'S MEDICAL CENTER

The Queen's Medical Center
Physicians Office Building 3, Suite 501
550 S. Beretania Street
Honolulu, Hawaii 96816
Phone: 808-691-8955 | Fax: 808-691-8950

Gastroenterology Services | Consultation Request Form

PLEASE COMPLETE ALL FIELDS Appointments will not be scheduled until all information is received

PATIENT INFORMATION		
Today's date:		
Patient Name:		Date of Birth:
Current Address:		Email:
Mailing Address (if different from above):		
Primary Phone #:	Secondary Phone #:	Other:
Patient's primary language: ☐ English or Other:		
Referring Physician:	Phone #:	Fax #:
PCP:	Can the patient ambulate independently? ☐ YES ☐ NO	
Health Insurance Information		
Primary Insurance:	Subscriber:	Subscriber ID:
Secondary Insurance:	Subscriber:	Subscriber ID:
Authorization Required ? ☐ YES ☐ NO		Authorization Number:

Reason for Referral

Request for Consult/Visit: ☐ Next Available ☐ ASAP (Call to Speak with Specialist)

☐ Screening ☐ Follow-Up

Other, please specify below:

DIAGNOSIS (REQUIRED)

ICD-10	DESCRIPTION	SPECIAL INSTRUCTIONS

ORDERING PHYSICIAN CERTIFICATION Via signature below, I hereby certify that the procedure(s) requested is/are medically necessary.

X

Physician Signature	Date	Time

Requested Provider:

☐ Dr. Christopher Aoki ☐ Dr. Gavin Park ☐ Next Available

☐ Dr. Larissa Fujii-Lau ☐ Dr. Brandon Yim

☐ Dr. Scott Kuwada ☐ Dr. Kraig Young

Please Complete this referral and Fax with copies of (as applicable):

1. Last two (2) office visit Notes
2. Lab Results/Reports
3. Imaging Reports
4. Previous Colonoscopy &EGD

QMC USE ONLY BELOW THIS LINE - ROUTING & SCHEDULING INFO

Date Request Received:	Attempts to Schedule (1st, 2nd, 3rd):				Appointment ☐ No ☐ Yes Date/Time: Provider:	PSR Initials:
				☐ RTMD		

Reviewed by: ______________________ ☐ APPROVED ☐ NOT APPROVED

Reason:

☐ See reverse for additional comments

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