Pulmonary Critical Care and Sleep Medicine Referral

1329 Lusitana Street Suite 704
Phone: 808-691-8725
Fax: 808-691-8716

REASON FOR REFERRAL:
□PulmonaryNodule/Mass/Bronchiectasis
□Sleep Problem

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

ROGER YIM, M.D.	MIKI UEOKA, M.D.
HALLEY TSAI, M.D.	KELLI FURUYA, APRN
BRADLEY TOKESHI, M.D.	
JAMES YANG, 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		Sleep Studies
	Insurance Card(s)/Authorization		Sleep Compliance Reports from DME
	Most Recent Progress Notes		MD notes who ordered sleep study
	Chest X-Ray/CT Images and reports		Complete Pulmonary Function Test
	PET scan Images and reports		
	Previous Pulmonologist Notes		

Comments: