THE QUEEN'S MEDICAL CENTER

CANCER CENTER- POB1 & KUAKINI

"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. Kenneth Sumida
☐ Dr. Carl Higuchi
☐ Dr. Jodi Kagihara
☐ Dr. Kaye Kawahara
☐ Dr. Gordon Nakano
☐ Dr. Ryon Nakasone
☐ Dr. Nicolas Villanueva
☐ Dr. David Y. Saito
☐ Dr. Shaun Donegan
☐ First available/No preference

Location Preference:

☐ **Queens POB I** - 1380 Lusitana St Suite 608
TEL: (808) 686-4222 FAX: (808) 686-4223

☐ **Kuakini** – 321 N Kuakini St Suite 412
TEL: (808) 686-4244 FAX: (808) 539-9337

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

Provider Name(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 received. 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 2023_10