Hawai'i Island Community Health Center

REFERRAL FORM

Hawai'i Island Community Health Center: Telephone: (808) 326-5629 • Fax: (808) 329-5057
**NOTE: Please attach Patient demographics, appropriate provider notes, labs, and imaging. Thank you!*

PATIENT INFORMATION

Last Name: _____ First Name: _____ Birthdate: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Guardian Last Name: _____ Guardian First Name: _____

Guardian Phone Number: _____

PATIENT INSURANCE INFORMATION

Primary Insurance Carrier: _____

Insurance ID Number: _____

Subscriber Name: _____ Subscriber Birthdate: _____

Secondary Insurance Carrier: _____

Insurance ID Number: _____

Subscriber Name: _____ Subscriber Birthdate: _____

REFERRING PROVIDER INFORMATION

Primary Care Provider/Facility Name: _____

Phone Number: _____ Fax Number: _____

Patient being referred to (please check one): ☐ Women's Health ☐ Pediatric Cardiology

MEDICAL/SERVICE INFORMATION

Diagnosis requiring referral (ICD-10 Code(s)): _____

Description: _____

Service Date(s): From: _____ To: _____

Number of approved visits (optional): _____