HAWAIʻI VISION

SPECIALISTS

OPHTHALMOLOGY & OPTOMETRY

Patient Referral form

Date: _____

Patient Name: _____ Age: _____ Sex: M F

Date of Birth: _____

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

Best person to contact if not patient _____Relation_____

Referring Doctor:_____Phone_____Fax_____

Medical Insurance: _____PCP:_____ PCP phone #_____

Subscriber Number: _____

Name of Guarantor if not self:_____ DOB guarantor:_____

Reason for referral: (Is this an emergency? Y N)

Note: Tricare and VA require authorization from the payer. Please include our fax number with your authorization request.

MIKIʻALA SOUZA, OD Ocular Disease Specialist • **DAN DRISCOLL, MD** Ophthalmic Surgeon

392 Kapiolani St, Hilo, HI 96720 • **T** 808.333.3233 • **F** 808.315.7663

hawaiivisionspecialists.com