



# HAWAI'I 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.

**MIKI'ALA SOUZA, OD** Ocular Disease Specialist • **DAN DRISCOLL, MD** Ophthalmic Surgeon

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