REHAB Hospital of the Pacific
Dedicated to Rebuilding Lives

PHYSICIANS CLINIC

Phone: (808) 544-3325 | Fax: (808) 535-2001

PATIENT NAME: _____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY INSURANCE: _____

❑ TRANSLATOR NEEDED: _____

REASON FOR REFERRAL: _____

- ❑ NEUROTRAUMA RECOVERY
- ❑ SPASTICITY
- ❑ OSTEOPOROSIS
- ❑ PAIN MANAGEMENT
- ❑ CONSULT
- ❑ EMG/NCS
- ❑ OTHER: _____

REFERRING PHYSICIAN NAME: _____

OFFICE PHONE NUMBER: _____ OFFICE CONTACT: _____

FOR WORK COMP ONLY:

CLAIM #: _____ DATE OF INJURY: _____

EMPLOYER: _____

ADJUSTER NAME: _____ ADJUSTER PHONE/FAX: _____

CASE MANAGER (IF APPLICABLE): _____

PLEASE INCLUDE the following with your referral:

- ☐ DEMOGRAPHICS
- ☐ LABS/IMAGING
- ☐ MD NOTES
- ☐ IF QUEST, PRIOR AUTHORIZATION (PA)