HI PAIN
HAWAII INSTITUTE FOR PAIN

Referral Form

Dr. Calvin Chen, D.O. **Dr. Jerald Garcia, M.D.** **Dr. Josianna Henson, M.D.**
Tel (808) 206-5301 Fax (808) 200-3785

Referring Doctor/Provider: _____ Clinic: _____
Clinic Tel #: _____ Clinic Fax #:_____

Patient Name: _____ DOB: _____

Street Address: _____City/State/Zip: _____
Home Phone: _____ Work: _____ Cell: _____

Please select preferred office location:

- ☐ **Honolulu:** 1401 South Beretania St. Suite 400., Honolulu, HI 96814
- ☐ **Waipahu:** 94-216 Farrington Hwy. Suite A102., Waipahu, HI 96797
- ☐ **Maui:** 39 W. Kamehameha Hwy., Wailuku, HI 96784

Reason for Referral: _____

Primary Insurance: _____ Subscriber ID # _____
Secondary Insurance: _____ Subscriber ID # _____

For Tricare Only: Sponsor's Name_____ Sponsor's SS#_____
For Work Comp or No Fault Referrals:
Insurance: _____ Claim #_____
Date of Injury:_____ Type of Injury: ___Work Comp ___No Fault
Adjustor Name: _____
Adjustor Phone #: _____ Adjustor Fax #: _____

For all patients, please attach any pertinent medical records including medication list, imaging reports, and authorization along with this document.
For Tricare, VA, WC and MDX HMO: Please attach completed authorization.

MAHALO FOR YOUR KIND REFERRAL!

FOR OFFICE USE ONLY

Referral request taken by: _____ Date:_____
Appt Date: _____ Appt Time: _____ M.D_____