

1010 South King Street Suite 111
Honolulu, Hawaii 96814

ph 597 8765
fax 597-6578

Date: _____
Patient Name: _____
Birth Date: _____

Referring M.D.: _____

- E-mail reply: _____
 - Fax reply: _____
 - Voice mail reply: _____
 - Mail reply: *(office stamp to right)*
 - Call me as you are seeing the patient. Ph: _____
 - Other:
-

Reason for referral:

Patient Information: *(brief history of medical problem)*

- Axolotl note dictated. Date: _____
 - Copy of clinic note attached/faxed
 - Records/X-rays arriving with patient
 - Voice mail sent
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Type of service desired:

- Opinion only
 - Help in joint management
 - To manage above problem; refer patient back after consult
 - Provide technical procedure only: Thoracentesis, bronchoscopy
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If additional services are required

- Call me before proceeding
- Proceed according to your judgment