HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

IMAGING OUTPATIENT PROCEDURE REQUEST FORM

	Phone	Fax
□ Kapiʻolani Medical Center for Women and Children	(808)983-8626	(808)983-8710
□ Pali Momi Medical Center	(808)485-4222	(808)485-4233
□ Straub Benioff Medical Center	(808)522-4221	(808)522-4240

Patient's Name: _____ Date of Service: ___/____/____
Last *First* *M.I.*

Date of Birth: ____/____/____ Weight #_____

Home Phone: _____ Cell Phone: _____ Is patient pregnant? □ Yes □ No

Primary Insurance Provider: _____ Policy #_____

Secondary Insurance Provider:_____Policy # _____

Authorization #_____□ Pending □ Waived □ No Authorization Needed

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Diagnosis: _____ICD Code(s):_____

□ X-Ray □ CT □ Ultrasound □ MRI □ Nuclear Medicine □ ECHO (KMCWC Only)

Exam: _____

History: _____

Personal or family medical history related to the procedure

Symptoms &
Chief Complaint: _____
Personal or family medical history to include allergies related to the procedure

_____
Any specific signs, symptoms or complaints related to this procedure; not "rule-out" or "routine"

Date of Injury: _____

Is this for Workers' Comp? _____

Ordering Physician Signature: _____ Date: _____ Time: _____

Print Name: _____ Office Phone: _____ Office Fax Number: _____

Comments/Special Instructions: