Kapi'olani Medical Center for Women & Children | Phone 808-983-8626 | Fax 808-983-8626
Kapi'olani Medical Women's Center | Phone 808-535-7000 | Fax 808-973-6537

KAPI'OLANI MEDICAL CENTER FOR WOMEN & CHILDREN
An Affiliate of Hawai'i Pacific Health

IMAGING OUTPATIENT PROCEDURE REQUEST FORM AND HHP HMSA AUTHORIZATION

Instructions: Complete this form, sign it and fax it to the department (numbers above) or give to your patient to bring to their appointment.

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

ICD Code: ______________________ Time of Exam: __________

ICD Desc: ______________________ Date of Birth: ____/____/____

CPT Code: ______________________ Home Phone: __________

CPT Desc: ______________________

History: ______________________
Personal or family medical history related to the procedure

Symptoms &
Chief Complain: ______________________
Personal or family medical history to include allergies related to the procedure

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

What questions do
you want answered? ______________________

Date of injury ______________________

Is this for
Workmens Comp? ______________________

____

Physician Signature: ______________________ ______________________
Required *Date*

Print Name: ______________________

Office Phone: ______________________ Office Fax Number: ______________________

Copy of Report To: ______________________

Patient to return to my office | Films and wet read | Wet read only
Films Only | Patient may leave | Other __________

FAX THIS REQUEST WHEN COMPLETED
HHP HMSA PRIOR AUTHORIZATION NUC/MED/STRESS ECHO Request 808-522-4174
Kapi'olani Medical Center for Women & Children 808-983-8710 or
Kapi'olani Medical Women's Center 808-973-6537