REHABILITATION HOSPITAL
OF THE PACIFIC
226 North Kuakini Street • Honolulu, Hawaii 96817
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PHYSICIANS CLINIC

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

Name: _____ Onset Date Illness/Injury/Accident: _____

Phone: _____ Surgery Date: _____

Reason for Referral: _____

Diagnosis: _____

_____

☐ NEUROTRAUMA RECOVERY	**Evaluate & Treat**	☐ SPASTICITY	**Evaluate & Treat**
☐ OSTEOPOROSIS	**Evaluate & Treat**	☐ PHYSIATRY	**Evaluate & Treat**
☐ OTHER			
☐ CONSULT			

Physician Name _____ NPI# _____ Physician Signature _____ Date _____

Case Manager
(If applicable) _____

Adjuster Name _____ Fax/Phone _____

FOR WORK COMP ONLY: Estimated Cost: _____(estimated by treating therapist)

PLEASE INCLUDE the following with your referral:

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