KAPI'OLANI MEDICAL SPECIALISTS
An affiliate of Hawaii Pacific Health

Hawaii Community Genetics Referral

FAX TO: (808) 973-3401

Hawaii Community Genetics will call the family to schedule an appointment once we receive this fax. We will contact your office closer to the appointment date to request an insurance referral.

Date: _____

Patient Name_____ DOB _____ Male/Female

Parent/contact Name_____

Patient Telephone_____ Insurance _____

PCP _____ Requesting physician (if not PCP) _____

REASON FOR REFERAL

☐ Positive Newborn Screen for _____ or ☐ Alpha Thalassemia (282.49)

☐ Confirmed Hearing Loss

☐ Developmental concerns
- Mental Retardation (319)
- Autism (299.00)
- Delayed Milestones (783.42)
- Language delay (315.32)

☐ Growth concerns
- Failure to thrive (783.41)
- Asymmetry/hemihypertrophy (759.89)
- Short Stature (783.43)
- Overgrowth/Tall Stature (783.9)
- Skeletal dysplasia, NEC (259.4)

☐ Birth defects_____

☐ Dysmorphic features (796.4)_____

☐ Neurologic symptoms _____

☐ Dermatologic
- Abnormal skin pigmentation (709.00)
- Ichthyosis/scaly skin (757.1)
- Café au lait macules (709.09)
- Vascular birthmarks (228.00)

☐ Patient has known/suspected chromosomal or genetic disorder _____

☐ Family history of chromosomal or genetic disorder _____

☐ Other _____

Medical record review is an important part of a genetic evaluation. Please send pertinent medical records with this referral including

1. Birth records including measurements
2. Specialist consults (neurologists, endocrinologists, cardiologist, ENT, etc)
3. Imaging studies (MRI, CT scans, X-rays)
4. Laboratory results (genetic tests, blood tests, urine tests, etc)
5. Growth curves (weight, height, head circumference)

Please reproduce this form as needed.