949 Kamokila Boulevard, 3rd floor, Suite 350
Kapolei, HI 96707

# Health Services Referral Form

Please use this form to refer a member to the
Service Coordination / Disease Management Department

## Fax to 1-855-703-8078 or Call Customer Service @ 1-888-846-4262

| **Member Information** | | |
|---|---|---|
| Name: | Phone #: | DOB: |
| Member ID #: | Other Health Insurance & ID #: | |
| Caregiver / Contact Person: | Phone #: | |

| **Referring Source Information** | | |
|---|---|---|
| Name of Referring Source: | Today's Date: | |
| Contact Name: | Phone #: | Fax #: |

☐ Physician's Office ☐ Public Health Nurse ☐ Nurse Advice Line ☐ Member's Family/Caregiver
☐ Member ☐ Care Manager (Agency) _____ ☐ Other _____

**Reason for Referral**

☐ Member needs assistance with medication compliance & adherence to medical treatment plan
☐ Member needs coordination of services
☐ Member needs screening for home-based services
☐ Member needs assistance accessing Behavioral Health services
☐ Member inquiring about foster home or long-term care placement
☐ Member needs health education in: ☐ Asthma ☐ Diabetes ☐ CAD ☐ Depression
☐ Other _____

Clinical Information / Other Information: *Include supporting clinical records, if necessary*

**Other Pertinent Information**

☐ Primary Diagnosis :
☐ Behavioral/Psychosocial barriers:
☐ Cognitive/ Physical deficits:
☐ Communication barriers:

***Completed by Health Plan Staff***

Referred to: ☐ SC _____ ☐ CCS _____ ☐CCM _____ ☐ DM _____

Screened by:_____ Screening Date: _____